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Painful Lessons

During medical school, the one thing I learned was that I disliked afternoon sessions in clinic. The endless parade of patients while bouncing between examining rooms lacked the drama and urgency of the operating room (O.R.) or the intensive care unit. Listening to a long litany of chronic complaints or checking blood pressure, while important, lacked the sense of significance I found in more invasive work. Thus I approached my pain rotation during residency with some trepidation. What would I find? My unending fear was a long list of patients with complaints that could neither be cured nor helped. Residents in my senior year of training did not help as they told me of the horrors of the pain clinic.

Yet the rotation was wonderful. It began with the attending staff who ran the rotation. Young, energetic and a marvelous anesthesiologist and physician, Gerald Peer, M.D., had time for each resident and the patience to teach us the nuances of pain medicine. He was diplomatic in guiding our diagnoses and skillful in teaching us the regional anesthetic adjuvants that were and are so important to pain medicine. As we decided what to do in our third year of residency, it was a great temptation to spend more time in the pain clinic.

On my first job after residency, management of acute postoperative pain was a critical skill as we built an acute pain service. All of the anesthesiologists were expected to care for these patients when on call, and each of us took weekly turns running the service. I learned a great deal about education that first year and how important it is to see that all members of the team caring for a patient understand the plan. Patience was another virtue I slowly developed, trying hard to remember that the nurse who did not know how to restart an epidural infusion needed to be taught, not criticized.

My next career stop was at a Veterans Administration hospital. There was a desire on the part of the hospital administration and the university chair with whom I worked to develop a pain medicine program. Resources were tight, and we could not hire any ancillary personnel to help with the service. Several of the anesthesiologists, myself included, saw chronic pain patients to try to help sort out those with treatable conditions from those who had other motivations for continuing to have pain. It was far from ideal.

In my most recent job, I have almost daily interactions with our excellent pain group. There is considerable crosstalk among the acute pain service and the anesthesiologist responsible for placing regional anesthetic blocks. At one of the hospitals in which I practice, an aggressive catheter service for lower extremity blocks has been developed, allowing patients with total hips and knees to ambulate better and have lower narcotic requirements. To watch them in practice is quite impressive.

Yet, recently, there was a movement afoot to have these anesthesiologists take only pain call and to leave O.R. call behind. While this is the national trend, it greatly saddened me. Anesthesiologists have been involved in pain medicine since the 1920s and have been leaders in the field for almost 85 years. Why is this separation occurring, and is it inevitable? Should “mainstream” anesthesiology be worried about this trend? A pain medicine colleague of mine recently expressed to me the opinion that there should be a certification for “interventional pain medicine” much the way there is for interventional radiology or cardiology. The field of interventional pain medicine would encompass blocks, spinal cord stimulators and like modalities and would be something unique to anesthesiologists. Interventional pain medicine would be consistent with anesthesiologists’ historic role in the field as well.

“As an anesthesiologist interested in pain medicine but not formally trained in the subspecialty, I watch on the sidelines and wonder what is happening to this important part of anesthesiology.”

While this is not a new idea, and it may be too late to implement, it is certainly a proposal that deserves action. As an anesthesiologist interested in pain medicine but not formally trained in the subspecialty, I watch on the sidelines and wonder what is happening to this important part of anesthesiology. By establishing “pain only” call and spending more and more of their time in the pain cli-
Will You Participate, or Sink Into the Shadows?

Candace E. Keller, M.D.,
Speaker of House of Delegates

The Ghost of Freedom’s Past

As a first-class citizen, I’d rate,
I’ve paid my taxes, pulled my weight.
Kept my conscience free from sin,
Gone to church, at least now and then.
With little leagues, I’ve learned to play,
I’ve suffered hours of PTA.
I’ve paid my bills, observed the laws
And given to many a deserving cause.

But politics was not my dish,
I’d rather golf, or hunt, or fish.
When I was asked by Mr. Pate
Would I support his candidate?
I said I’d sent a prior check —
’Twas all a lie ... but what the heck.
When called to work for Senator White,
I said my schedule was too tight.
When precinct meetings rolled around,
I said that I was leaving town.
When Party help was needed now,
I said, “They’re all crooks, anyhow.”
Then when it came the time to vote,
I spent the day out in my boat,
And life rolled on, day in, day out
About my future, I’d no doubt.

Then one night while dreaming fast,
I met the Ghost of Freedom’s Past.
He led me from my snug, warm bed
To show me things that lay ahead.
He showed me faces, thin and bleak,
On folk who toiled through endless week,
Meeting quotas, reaching goals,
Living under strict controls.

I’d been assigned...he then decreed,
To clinics where there was a need.
I’d have a bed and board and clothes
With coupons to exchange for those.
For such I’d file a six-part claim
But sign my number, not my name,
And serve each day without complaint;
Managed Care had now become my Saint.

There’s just no way for legal fights;
The Courts are closed, and you’ve no rights.
You had a chance to survive,
To keep this marvelous thing alive.
You simply said, “That task’s a bore.”
Now this is two thousand and four,
For all the world, you didn’t care
While there were others waiting there.

To call your lifestyle to a halt,
You lost your freedoms by default.
You gave it up inch by inch;
Those activists ... they had a cinch.
So here it is, no hope, no money,
Don’t cry on me ... you blew it, honey!
And just then, I awoke in sweat
But I recall that nightmare yet.

Of life, with which I could not cope,
Devoid of dreams, devoid of hope,
Devoid of warmth, devoid of love,
Devoid of guidance from above.
I saw the error of my ways,
And I will spend my lasting days
Preserving all that we can be,
A profession proud and strong and free.

— Adapted from a poem by Rex Kenyon, M.D.

There are many ways you can make a difference. ASA needs and wants your involvement both in your local component societies and at a national level. You, the members, are what this organization is all about, and we need your input to be as successful as we can be. The ASA Political Action Committee continues to work on behalf of all anes-
In late June, the Supreme Court unanimously decided that the terms of the Employment Retirement Income Security Act (ERISA) bars health maintenance organization (HMO) subscribers from suing in state court to recover damages flowing from refusal by the HMO to cover medical services deemed appropriate by their physicians. The court said that such suits could, under ERISA’s terms, be brought only in federal court where damages are limited to the cost of the denied care, not for other compensatory or punitive damages.

The court said that when a state suit is solely based on denial of coverage under the terms of an ERISA-regulated employee benefit plan and no violation of the plan is alleged, then the terms of ERISA clearly indicate the congressional intent to pre-empt state remedies in favor of a suit in federal court. The court said that when a state suit is solely based on denial of coverage under the terms of an ERISA-regulated employee benefit plan and no violation of the plan is alleged, then the terms of ERISA clearly indicate the congressional intent to pre-empt state remedies in favor of a suit in federal court.

Immediately after issuance of the decision, several Democratic legislators announced the intention to reintroduce the Patients’ Bill of Rights legislation that foundered in the 107th Congress. Both congressional bodies passed such legislation, but differences in the two bills were never resolved in conference. There is virtually no likelihood that such a bill would reach the floor of either body before adjournment of the 108th Congress, but depending on the outcome of the November elections, the matter could receive significant congressional attention next year.

Medicine Seeks Senate Action on Patient Protection Bill

ASA joined more than 100 other state and national medical specialty associations in sending a June 12 letter urging members of the Senate to advance the Patient Safety and Quality Improvement Act (S. 720), pursuant to which a system would be created by which health professionals could share in confidence and analyze information about medical errors. A similar bill (H.R. 663) passed the House by a wide margin early in the 108th Congress. The Senate bill has been ready for floor action for several months but has been held up by concerns from Democrats that its provisions could unnecessarily impede the obtaining of records and information sought by patients seeking redress for alleged professional malpractice. On July 14, Senator Judd Gregg (R-NH), Chairman of the Health, Education, Labor and Pensions Committee, once again failed in an attempt to obtain unanimous consent to bring the bill to the Senate floor. ASA has actively supported both the Senate and House bills throughout the 108th Congress, but with few legislative days remaining in this Congress, the chances of passage are becoming more and more bleak.

Majority Leader Frist also has not followed through on plans, announced several weeks ago, to seek floor action on a third professional liability bill, the coverage of which would be limited only to certain specialties or locales. Supporters of these bills have fallen far short of the votes required for cloture, and doubt currently exists whether the Senate leadership will try again in the current session.

Not-for-Profit Hospital Billing Rates Questioned

At hearings before the health subcommittees of the House committees on Ways and Means and Energy and Commerce, Republican legislators raised questions in late June as to whether tax-exempt hospitals were providing a level of charitable services commensurate with the tax benefits they enjoy in contrast to for-profit hospitals. These benefits are substantial: as reported by the Ways and Means Committee staff, although hospitals represent less than 2 percent of the total number of tax-exempt organizations, they account for about 41 percent of total expenditures of these bodies.

Continued on page 4
Specific attention was focused at these hearings on the fact that some tax-exempt hospital billing rates to the uninsured are higher than those charged to insured patients. This state of affairs has led to the introduction of a number of class action lawsuits against not-for-profit hospitals, alleging that these hospitals are not sufficiently fulfilling their statutory mandate to provide charitable care in exchange for tax exemption.

**Member Comments Sought on D.C. Office’s Services**

As members of the ASA House of Delegates are already aware, I will be retiring as Director of Governmental and Legal Affairs at the end of the year. The officers are in the process of conducting a search for my successor, and their intention is that the successful candidate will have been selected by the time of the ASA 2004 Annual Meeting in late October.

My decision to retire from my current position stemmed from my conviction that after 11 years on the job (and 25 years as ASA legal counsel before that), it was time for the Society to benefit from new approaches and new ideas in terms of service by this office to the membership. In this context, I seek your assistance.

You are invited to write me with suggestions on how the Washington Office can improve its services to the membership. Currently we are responsible for presenting the Society’s position on legislative or regulatory issues to federal and state officials (the latter in cooperation with the various state component societies), keeping the membership abreast of important legislative and regulatory developments, providing legal advice to the Society in tandem with outside counsel and assisting those who are charged with anesthesiology practice management.

Much of our work focuses around the Medicare program, but we are involved with other insurance programs as well. For many years, we have been active with respect to scope-of-practice issues. A principal current concern is, of course, passage of federal legislation that would assure the availability of professional liability insurance at affordable rates. Please do not feel confined in your comments to our current undertakings, however. This is a good time for the ASA leadership and my successor to evaluate whether we should be moving in a different direction or pursuing different priorities.

Most of you can conveniently reach me via e-mail at <m.scott@ASAwash.org>, but some may wish to write me at 1101 Vermont Ave., N.W., Suite 606, Washington D.C. 20005. If you prefer, comments may be sent to ASA Executive Director Ronald A. Bruns at <r.bruns@ASAhq.org>. All communications will be passed on both to the principal ASA officers and, with their concurrence, to my successor. If you are moved to comment favorably or unfavorably on my personal performance in the job, I urge you instead to send a contribution to one of the foundations supported by ASA: this is not about what I have or have not done, but what this office might do better under new stewardship. In any event, no comment will be published in the NEWSLETTER without the express permission of the communicating author.

As Speaker of the ASA House of Delegates, I urge you to consider what you can do. As individuals, we can do much; corporately, we can do even more! Our tomorrows will largely be determined by our choices today. Will we be haunted by ghosts of freedom’s past? The decision is ours to make! The ASA Annual Meeting is fast upon us. This is an important election year in both congressional and presidential races. Don’t delay — get involved today!
The Changing Face of Pain Medicine

Doris K. Cope, M.D.
Committee on Pain Medicine

The articles in this issue were selected to demonstrate to the anesthesiology community the new concepts salient in pain medicine today. As in any new movement, political or philosophical, diverse ideas prevail. But to ignore the tide of change is to be swept away in the current. The departments and private practices that have embraced the developing field of pain medicine have now established thriving divisions. Those who have ignored the field, or practiced in outmoded ways, are left behind in the competition.

It has been interesting for me to note that, in some cities, private practitioners take the lead, and the academic practices are woefully inadequate with nonsolvent pain divisions that do not offer the latest therapies and have difficulty recruiting any, much less enthusiastic, fellows and staff. In other similarly sized cities, academic pain practices have grown from a minimal service to divisions serving thousands upon thousands of patients a year, and the private practitioners face much harder competition. The ASA Committee on Pain Medicine has brainstormed ideas for this NEWSLETTER, and we hope that the diversity and excitement of pain medicine will be reflected in this issue.

The articles in this issue range from the discussion of practical concerns in combining an anesthesiology operating room practice with a pain practice. Mazin Al Tamimi, M.D., a former neurosurgeon, describes why he personally wanted to train in pain medicine and, as such, also reflects the face of anesthesiology’s future (page 6).

In “Pain Medicine and Anesthesiology: Oil and Water? Or Do They Mix?” (page 7), somewhat different but complementary views by James P. Rathmell, M.D., and Timothy R. Deer, M.D., are presented.

Exciting new research directions in pain are discussed by James C. Eisenach, M.D., on page 10.

A futuristic perspective is presented by Scott M. Fishman, M.D., of a time when pain medicine might follow the example of emergency medicine in establishing its own independent curriculum and training (page 12).

In this context, Douglas G. Merrill, M.D., discusses on page 14 what ASA is doing and has done to help pain medicine physicians receive proper reimbursement for their services.

We hope you enjoy this issue and find it enlightening and challenging.

Doris K. Cope, M.D., is Director, University of Pittsburgh Medical Center (UPMC) Pain Medicine Program, and Professor of Anesthesiology, UPMC, Pittsburgh, Pennsylvania.
Why I Chose to Become a Pain Medicine Fellow

Mazin Al-Tamimi, M.B., Ch.B.

Dr. Al-Tamimi reflects the diversity of physicians today who choose to specialize in pain medicine. His personal story of leaving Iraq for the United States contrasts with that of his brother, an orthopedic surgeon who had to flee his practice in Basra due to political persecution. Dr. Al Tamimi’s skill in diagnosing and treating patients was evidenced throughout his fellowship. He joined the St. Joseph’s Hospital of the Marshfield Clinic, Marshfield, Wisconsin, in July 2004.

— Doris K. Cope, M.D.

Changing one’s personal career is not a simple decision. All of the major decisions I made during my life, however, were reached with one goal in mind — to be the best physician I could be. I changed my career from neurosurgery to internal medicine to pain medicine, and, at the end, found that pain medicine best fulfills my goals.

Although I trained as a neurosurgeon after I finished medical school, my fascination with pain medicine began a few years ago. I found the practice of pain medicine to be exciting, challenging and rewarding. I do not find the hard work in this field burdensome at all. Rather it has been nothing but a pleasure and has given me great satisfaction.

During all the years of my training in neurosurgery, I saw and treated a lot of patients with multiple injuries resulting from the wars in the Persian Gulf region who suffered from acute pain in the beginning and later from phantom and chronic pain. At that time, there were no pain specialists to which to refer these patients. We needed to treat our patients’ suffering on our own. Those unfortunate days of war gave me a strong incentive to search into the field of pain medicine.

Later when I started practicing neurosurgery, pain medicine continued to fascinate me, especially when I sought to refer a failed back-surgery patient to a pain medicine physician and began to treat trigeminal neuralgia patients on my own with glycerol injections. My continued interest in this field increased substantially, especially after I read more about the history of the revolution in pain medicine from the days of John J. Bonica, M.D., to the present.

When I came to the United States, I kept my interest in pain medicine in mind. I never stopped searching to find a pain fellowship. I tried to get an anesthesiology residency, planning that I would become a pain medicine physician at the end, but because of personal matters, I ended up finishing an internal medicine residency (which I never regretted). Internal medicine and my past neurosurgical training have helped me to succeed in my fellowship.

I became increasingly interested in pain medicine after I started my fellowship because this field offered me greater opportunities for learning than any other specialty. Pain medicine requires leadership, technical skills and a broad background. Each medical case offered me a new learning experience. The only subspecialty that joins other specialties with one common symptom is pain.

A few months ago, my daughter asked me what my specialty was. I told her it was pain medicine. She replied, “But any part of the body can suffer from pain, so you need to know about everything.” I explained to her that that was why I love this specialty, as it widens your knowledge base, is challenging and provides me with the ability to give the best care I can to my patients.
Pain Medicine and Anesthesiology: Oil and Water? Or Do They Mix?

What is pain medicine? Is it a full-time endeavor or a field that is easily practiced as a small aside within an operating room (O.R.) anesthesiologist’s daily routine? I aim to outline the conflicts that arise between anesthesiology groups and their pain medicine subspecialists. With an understanding of these friction points, anesthesiology groups can successfully integrate pain medicine practitioners.

Imagine you are a practice manager who is grappling with keeping an existing pain group in check, or perhaps you are contemplating expanding an existing pain practice to offer the “full scope” of pain medicine to your patients. What are the problems you will face? In an insightful editorial, former ASA NEWSLETTER Editor Mark J. Lema, M.D., Ph.D., wrote knowingly of the tensions that arise between pain medicine practitioners and their anesthesiology colleagues practicing exclusively in the O.R. setting. Understanding both perspectives is essential to integrate pain medicine practitioners within an anesthesiology group.

This Is a Democratic Group, Right? (“Let’s Vote on It.”) It is not likely that the size of pain groups will rival that

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With the development of syringes and open-bore needles in the 1850s, physicians began to treat pain with increased interest and abilities. In modern medical care, acute pain is often treated by anesthesiologists using regional techniques and intravenous infusions to alleviate discomfort. Anesthesiologists have been the logical choice to treat these patients because of our knowledge of pharmacology and physiology and our ability to perform regional anesthesia. In the area of postsurgical pain and acute post-traumatic pain, anesthesiology should be the specialty to address the patient’s needs.

With the exception of this arena, anesthesiology has very few similarities to the practice of pain medicine. The practice of pain medicine, involving those with chronic pain of cancer and noncancer origin, more closely resembles that of our surgical colleagues. The practice resembles surgical-based practices because it is based on office evaluation and procedure-based treatment.

The differences in practice dynamics and characteristics make combining anesthesiology and pain medicine a losing formula for all involved. Because of the differing priorities

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James P. Rathmell, M.D., Chair Committee on Pain Medicine

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PRO

James P. Rathmell, M.D., Chair Committee on Pain Medicine

CON

Timothy R. Deer, M.D.
Committee on Pain Medicine

Timothy R. Deer, M.D., is Director and CEO, Center for Pain Relief, Charleston, West Virginia, and a clinical faculty member at West Virginia University School of Medicine, Charleston, West Virginia.
of anesthesiology groups. Pain practitioners, for the foreseeable future, will be a minority unless they are independent of anesthesiology groups. If every decision affecting the pain group is put to a vote of the entire anesthesiology group, the pain folks will always lose, thus setting the stage for a disgruntled minority.

Is the Work Equivalent? (“You’re Goofing Off in the Pain Clinic, While I’m Working Hard.”) There is a universal tendency to assume that when you cannot directly observe what your colleagues are doing, they must be goofing off. This is a powerful and destructive force that operates against the pain practitioner. Pain work is real work. If your pain colleague shows up an hour late to assume O.R. call duties because he or she was completing a consult, that should be recognized as real work. On the other hand, the potential for abuse is very real. Dictations and consults can be done at various times throughout the day, and the pain practitioner may choose to leave duties for day’s-end to avoid O.R. call responsibilities.

Are We Equally Productive? (“I Should Be Paid More Than You.”) Productivity in the O.R. is largely beyond the anesthesiologist’s control. In the pain clinic, though, productivity is directly controlled by each practitioner. Leaving productivity unrewarded in the pain clinic inevitably leads to either poor productivity or unhappy pain practitioners.

Can Clinicians Effectively Master Both Pain and O.R. Practice? When I return to the O.R., I find it to be a refreshing break. As I spend less and less time in the O.R., though, my skills become rusty, and my level of comfort declines. There is more than enough to master in the pain clinic: the minor surgical skills needed to place implanted devices, interventional techniques and the knowledge and skills needed for comprehensive care of chronic pain patients. These skills are just not a part of the O.R. anesthesiologist’s armamentarium.

Can We Be Expected to Share Call? At some point, the specialized skills required of the pain practitioner and those required of the O.R. anesthesiologist will diverge to such an extent that cross-covering on-call duties will no longer be reasonable. Unless your pain specialists spend significant time in the O.R., it is unreasonable to expect them to safely and comfortably cross-cover in the O.R. Likewise, the non-pain practitioner cannot be expected to know how to manage most of the patients seen in an interventional pain practice. A famous quote from one of my own cross-covering colleagues: “Ma’am, I don’t know what to tell you, I’ve never even heard of IDET.”

Let us look at practice styles that some have used successfully, at least for a time, to integrate anesthesiology and pain medicine.

and endpoints, the two specialties cannot be mixed in a manner that is optimal for either practice.

Different as Night and Day. The dynamics of a successful pain medicine practice differ from anesthesiology in every aspect. The daily challenges of a successful pain medicine practice involve controlling an office overhead that can approach 50 percent of collections, maintaining and managing a staff with complex and different roles, meeting the vigorous demands of documentation for evaluation and management codes and documenting medical necessity for procedures that may be poorly understood by insurers. Pain reimbursement is based on a complex documentation system that requires a thorough knowledge of medical necessity, diagnosis-based appropriateness and insurance-approved procedure codes. The ability to achieve these goals requires a full commitment to success in the pain arena.

The Paper Chase. A successful pain practitioner also must concentrate on balancing a financially viable practice with quality care and patient access. This requires controlling payer mix, insurance participation, procedure selection and additional continuing education. In an anesthesiology-based practice, the surgeon often determines what payers are accepted into the practice, what rates are negotiated and what hours the practice will be open. In groups where pain and anesthesiology are joined, the requirements of the operating room (O.R.) practice to take all comers brought forth by surgical colleagues becomes an obstruction to the goals of the pain medicine practice.

The practice of pain medicine requires extensive documentation with the average physician spending 10 hours a week in the process of updating records by dictating notes, writing letters and creating letters of medical necessity. These services are required to be reimbursed but do not have any direct financial billing for the time spent; this represents another major hurdle in the pain/anesthesiology relationship. Many groups find conflict when trying to decide on reimbursement for the pain doctor who may work longer
We’ll All Do Pain. Some groups have chosen to share and share alike. All practitioners do some pain work, which minimizes cross-coverage and productivity quarrels. Indeed some practitioners enjoy pain practice — as long as they do not have to do too much pain. I have yet to see a chronic, full-service pain clinic, however, where there is not at least one practitioner who spends the majority of his or her time in the pain clinic. Offering comprehensive services, managing office staff, assuring availability and continuity of care and progressing into more difficult areas of interventional pain medicine require a tremendous effort that needs leadership. The all-partners-do-pain groups will inevitably limit themselves to the simpler techniques that minimize the need for close follow-up and numerous telephone calls between infrequent times in the clinic.

A Few, Mostly Pain Practitioners, Who Do Enough O.R. to Share Call. This works quite well for the anesthesia group — having your cake and eating it, too. It puts the onus of responsibility on the pain practitioner to whip the pain clinic into a full-time, well-run operation but stay up-to-snuff enough to relieve the anesthesiologist in the O.R. This is where I believe many groups have stalled in development.

Hire Folks Who Specialize, But Keep Them in the Fold. I believe this is where the majority of young fellowship-trained practitioners are going today. They are close enough to residency to have some allegiance to the O.R. anesthesiologist; they are young and hungry and risk-averse as they are usually saddled with significant debt from their years of education. Anesthesiology groups have deep enough pockets and significant business skills to offer turn-key operations to these practitioners. Beware, though: the nonproductive will quickly appear as a drain on the anesthesia group while the very productive will soon be asking for additional, productivity-based salary increases. Both lead to dissatisfaction and the demise of the congenial relationship.

Pain and Pain Only. Many former anesthesiology group members have gone this route. Once they realize that they can control their own lot in life without answering to an unsympathetic group, they are gone. Indeed anesthesiology groups who have opted out of the pain business are becoming all too common. A few years with a working pain clinic is enough for the hospital and the physician community to mourn the loss. More and more hospitals are entering the business of establishing pain practices, and they are not at all shy about turning to the increasing wealth of physiatrists who have pain medicine training.

With an understanding and sensitivity toward the most frequent strains, pain medicine practitioners and other anesthesiologists can remain as happy and productive partners, but the reasons to stay together are dwindling.

Reference:

hours, but with no receipts to show for up to a third of the time. There is no reimbursement based on time units for pain; therefore, an equitable salary model cannot exist in a practice that houses both types of practitioners.

Communication Breakdown. In our experience of consulting with many anesthesiology groups, another large hurdle is the ability to understand the diverse roles each physician plays. The demands on the pain physician are not often understood by the anesthesiology practitioner, and the demands of the O.R. practice are not often understood by pain clinicians. These problems with communication often lead to conflict. In many scenarios, anesthesiologists want call relief in the operating theater when the pain physician is still seeing patients in the clinic. This can lead to resentment by both parties and an attitude of “I am working harder than them” exhibited by each group. Perhaps the most difficult role of all is the physician who attempts to do both types of practice. In many situations, the requirements to meet the needs of pain patients conflict with the need to take anesthesia call and care for patients. In such settings, this leads to less-than-optimal care for pain patients and difficulty in providing adequate O.R. coverage.

In summary the practice of pain medicine is not the practice of anesthesiology. To try to persuade ourselves otherwise is dishonest. Groups persisting in trying to mix the two often lead to failure in their pain practices financially and, most tragically, failure to provide the best care possible for those who suffer. We should strive to practice pain medicine as a commitment that has a primary goal of long-term success with good patient outcomes and financial viability. The practice of O.R. anesthesia does not allow for this commitment to be pursued with the necessary vigor for a pain practice to develop in a quality fashion that our patients deserve.

Pain medicine and anesthesiology truly are oil and water. You can shake them up and make them appear to be a solution, but in the end, they will always separate.
Trends in research are clearly in the eye of the beholder, but what follows is my opinion of some of the major themes in recent basic science research in pain. Perhaps not surprisingly, the basis for these themes is similar to that of other areas of neurobiology and neuroscience, reflecting the tight integration and rapid spread of methods and concepts across laboratory disciplines.

**Opioid Drug Action**
Clinical use of opioids in the treatment of chronic pain is controversial due to an unknown risk of tolerance, addiction and lack of efficacy. Each of these has a correlate in basic science research. Basic science studies suggest that opioid tolerance may reflect traditional mechanisms, such as desensitization or downregulation in the number of receptors, when exposed chronically to an agonist. Recent work shows that these phenomena occur in a nonhomogeneous manner across the nervous system, perhaps explaining differing degrees of tolerance to different aspects of opioid drug action. Receptor desensitization has been shown to occur rapidly in the spinal cord during chronic intrathecal drug administration.

Other less traditional mechanisms of tolerance also are under investigation. For example the reduction in opioid analgesia with prolonged exposure might reflect a paradoxical opioid-induced opposing process. Opioid-induced hyperalgesia occurs after acute and chronic drug administration in animals, and the cellular mechanisms in the spinal cord by which this occurs mimic those responsible for hyperalgesia from experimental nerve injury.

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**Future Trends in Basic Science Pain Research**

James C. Eisenach, M.D.
Committee on Pain Medicine

“[A]lthough we have focused on descending inhibitory mechanisms to the spinal cord for decades …

Finally, although we have focused on descending inhibitory mechanisms to the spinal cord for decades, recent work suggests that chronic pain may be due in part to descending facilitatory, pain-enhancing systems. Some recent evidence suggests that loss of opioid effect with persistent exposure disappears when these facilitatory pathways are disrupted.

**Peripheral and Central Sensitization**
Nerve endings are speculated to become sensitized in several clinical settings, and recent work has focused on multiple mechanisms by which peripheral sensitization occurs. Prostaglandins and catecholamines sensitize peripheral nerve endings 1) with a time course far outlasting a brief period of exposure, 2) by different mechanisms in males than females and 3) by interacting with proteins that make up the cell cytoskeleton. Indeed an emerging area of interest in neurobiology is the role of cytoskeleton proteins to divide the cell into compartments, many of which are specific to how membrane surface receptors produce their signals.

Another cause of peripheral sensitization and analgesic drug action involves interaction between resident or recruited immune cells and peripheral axons or their support cells. Inflammatory reactions are now known to occur throughout the length of a nerve after a focal injury, and immune cell products, including various cytokines and growth factors, are taken up by axons and result in local changes in excitability or transportation to the cell body where they alter genetic transcription. Areas of recent basic science in the phenomenon of central sensitization include release of peripherally transported cytokines to activate spinal cord
glial cells, glial-neuronal interactions in the spinal cord and activation of descending facilitatory mechanisms to enhance pain.

**Genetic Changes**

Initial screens of changes in gene transcription in the peripheral and central nervous system after injury leading to neuropathic pain focused on times two to four weeks after injury. Not surprisingly, in addition to ion channels and receptor changes, genetic changes at this time are dominated by inflammatory response genes. Interestingly, recent work shows that transcriptional changes which occur several months after injury, in the face of sustained neuropathic gene transcription at later time periods than this questions the relevance of these observations to patients with long-standing pain.

**Ion Channels as Targets for Analgesics**

If anything, the focus on ion channels as novel analgesic targets has increased in recent research. Unlike traditional analgesics such as opioids, which act on G protein-coupled receptors, tolerance does not occur to drugs acting at ion channels for analgesia. Multiple changes in sodium channel subtypes have been described in several animal models of pain, and many basic science and pharmaceutical company laboratories are busy developing and studying drugs that act specifically at certain subtypes which change their expression in peripheral nerves and the spinal cord in pain states. The molecular site of gabapentin action also is intensely studied, and recent work in genetically modified mice strongly suggests that this drug acts to relieve neuropathic pain by actions on certain types of calcium channels.

Basic science research in pain is rapidly advancing our understanding of opioid drug action, peripheral and central mechanisms of sensitization in neuropathic pain, genetic changes that occur after injury to the nervous system and lead to pain, and ion channels as emerging and tempting targets for novel analgesics.

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**From the Crow’s Nest: Painful Lessons**

Continued from page 1

ic, O.R. anesthesiologists lose touch with their pain medicine colleagues. Having pain physicians in the O.R. environment is helpful, for they serve as a resource on many matters and also a reminder of another part of the mission of the anesthesiology department. Lacking an O.R. presence, like the highly successful basic science researcher, these physicians lose touch with their home specialty, and the specialty with them. It is always harder to look individuals in the eye and tell them they are not part of the department than it is to cut off a clinic outside the department.

As O.R.-based physicians, we need to be sensitive to the issues that surround our colleagues in the pain clinic. Their hours, while different from an O.R.-based practice, may, in fact, be longer. Issues of office space, which sound foreign to many in the O.R., are of crucial value to our pain colleagues. Getting the right equipment (such as fluoroscopy units) and finding O.R. time, not at the end of the day, but at a mutually convenient time, also is important. Salary and reimbursement issues may be different, and they may challenge conventional thinking.

In the end, we are all anesthesiologists regardless of the subspecialty we practice. As such it is our undertaking to eliminate pain whenever possible, either from the scalpel or other painful conditions. It is time for those of us in the O.R. to remember our colleagues in the pain clinic and value their expertise; and pain medicine physicians should understand that they are needed and supported in anesthesiology. Only then will we be able to begin to fulfill the promise unleashed in the 1840s in the United States — freedom from pain in modern anesthesia!

— D.R.B.
The new specialty of pain medicine has developed during a time when medicine and society are re-examining their commitment to caring for pain. Public demand for improved medical attention to pain is growing in parallel with increasing regulations and standards for pain-related assessment and treatment. Likewise, mandates for primary and continuing education in pain care for medical students and physicians also are escalating, and administrative and legal actions against physicians who do and do not treat pain are receiving increased media attention. The identity of pain medicine is evolving against this backdrop.

Scott M. Fishman, M.D., is Professor of Anesthesiology and Chief, Division of Pain Medicine, Department of Anesthesiology and Pain Medicine, University of California-Davis School of Medicine, Sacramento, California.
Unlike other recognized medical specialties, there is no clear consensus on the content or duration of specialized training and experience required to become a proficient pain specialist. To date, the many primary disciplines that contribute to the knowledge base and clinical application of pain medicine have been unable to consolidate the complexity of pain into comprehensive curricula or universally accepted training requirements.

**Certification**

Two distinct pathways for specialty certification in pain medicine began at almost the same time. The American Board of Anesthesiology (ABA) approved a certificate of added qualification (CAQ) in pain management in 1991. This certificate was followed by applications for subspecialty certification in pain management from the American Board of Psychiatry & Neurology (ABPN) and the American Board of Physical Medicine & Rehabilitation (ABPMR) in 2000. The American Board of Pain Medicine (ABPM) was formed in 1991 to address the multidisciplinary training and experience necessary for the specialty of pain medicine and to offer certification to qualifying physicians from all medical specialties. Medical licensure boards in California (1996) and Florida (1999) recognize the ABPM board certification as equivalent to ABMS board certification, and ABPM diplomates in the state of Texas have been determined to be qualified to advertise themselves as board-certified. ABPM is seeking ABMS recognition as a primary specialty. Currently ABPM certifies 1,768 diplomates, of which 1,048 are anesthesiologists.

The ABPM certification examination in pain medicine is an eight-hour, psychometrically validated, practice-related examination developed in conjunction with an educational testing organization. The examination tests the knowledge and cognitive skills necessary to provide comprehensive pain care as determined from surveys of pain medicine and pain management physicians from a variety of parent ABMS specialties. The examination is offered once per year to qualified individuals, and unlike the ABMS-recognized CAQ, sets a standard for passage that is fixed irrespective of the candidate’s primary training specialty. Basic eligibility requirements include completion of an ACGME-accredited residency program that includes identifiable training in pain care, board certification by an ABMS member board, at least 18 months of clinical practice of pain medicine and at least 50 hours of category 1 continuing medical education credit relevant to pain medicine in the two years prior to sitting for the examination.

The recent addition of ABMS-approved certification through ABPN and ABPMR indicates that organized medicine is recognizing the multidisciplinary nature of pain medicine, which does not fit under any present single ABMS specialty. ACGME and ABMS are attempting to resolve the problems with our current system of pain specialty training, especially the need for more comprehensive, multidisciplinary training of pain specialists. Proposed solutions include requiring more multidisciplinary input and lengthening current subspecialty-style fellowship programs from one year to two or more years.\(^1,2\) The added time burden of extended fellowship training after residency, however, might be a disincentive for new physicians to enter the specialty at a time when more, rather than fewer, pain specialists are needed. Residency and fellowship training requirements for the field of pain medicine have been developed jointly by the American Academy of Pain Medicine (AAPM) and ABPM, which have made recommendations to an ACGME task force.\(^3\) Another ACGME task force also is considering recommendations from ABMS member boards to consider lengthening present fellowship requirements and requiring more multidisciplinary input.

**Where Will Pain Fit In?**

Pain medicine is currently practiced as a subspecialty of multiple medical specialties without any single specialty clearly being the most appropriate. How this new field is integrated within health care will greatly affect the ability of medicine to meet its mission and obligation to understand and treat pain. Without changing current practices of medical education and clinical care, medicine appears poised to continue to incur more regulations and laws that will require it to do so. The necessary changes will require unification of the disparate parts of pain medicine that currently reside within multiple specialties. Potential solutions include continued development of programs under the auspices of disparate disciplines that may not work well together to encompass the full scope and practice of pain medicine or development of pain medicine as a primary specialty. In either case, revising our current system of pain education and training for future pain specialists will not be painless.

References:


American Society of Anesthesiologists NEWSLETTER August 2004 ■ Volume 68 ■ Number 8
In the past few years, as more anesthesiologists have chosen to make pain medicine either a majority emphasis or even the sole focus of their practice, ASA leadership also has made the support of that discipline a priority. Despite unprecedented pressures placed upon ASA in regard to economic and political issues surrounding operating room practice, ASA officers and staff of the Washington Office have focused on the needs of pain medicine practitioners. This can be seen in the Society’s relationships with public and private payers, governmental regulators, the American Medical Association and various other pain specialty societies.

ASA’s attention to pain medicine also is evidenced in the development of several new Current Procedural Terminology™ code initiatives, in support of the educational efforts of the American Society of Regional Anesthesia and Pain Medicine (ASRA-PM) and in an unprecedented amount of time dedicated to pain medicine workshops, lectures and panels at the Annual Meeting. In addition I can testify that there are some very large brains among our colleagues on the Committee on Pain Medicine and the Committee on Economics who are working to protect the interests of anesthesiologists who provide pain medicine services. *I see smart people!* Some of these efforts go unseen by the membership at large, but the past few months of work by the leadership and staff have resulted in some excellent gains for pain practices. In this article, I discuss some of those efforts and also some of the Internet resources available to the pain medicine practitioner. Both ASA and your computer can be significant aids as you manage your practice. I also will mention a hot topic concerning the use of an evaluation and management code on the same day a procedure is done.

**ASA and Carrier Reimbursement and Documentation Policies**

Working with the physician members of the ASA committees on Pain Medicine and Economics, the ASA staff has quietly effected improvements in restrictive reimbursement policies by payers for both chronic and acute pain, even before they were published. For instance, hard work in such situations has now led to edits by McKesson and Aetna that allow unbundling of fluoroscopy charges (76005) from spinal injection codes. Practitioners who find payer or Centers for Medicare & Medicaid Services (CMS) carrier policies of concern or who encounter reimbursement decisions that seem inappropriate or unfair have found success in altering them either by contacting a member of the Committee on Pain Medicine <www.ASAhq.org/aboutASA/ASACommitteeListing.htm> or by calling the able staff of the ASA Washington Office at (202) 289-2222.

**What the Internet Can Tell You About Reimbursement and Documentation**

Members are reminded to keep track of Medicare carrier policies by monitoring where such policies are posted for evaluation prior to commitment as well as after adoption <www.cms.gov/mcd/search.asp>. These policies, once referred to as Local Medical Review Policies, or LMRPs, are now known as Local Coverage Determinations, or LCDs, and are posted before they are adopted, allowing comment by concerned practitioners. Once you find your own state’s Web page, set it as one of your browser’s “favorites.” It is a good idea to habitually set aside a few minutes once each month (e.g., the first Tuesday) to make sure you do not miss any potential changes in policy. The value of such vigilance by individual practitioners cannot be overemphasized. Carriers are responsive to pain practitioners’ concerns, particularly if they work through their Carrier Advisory Committee (CAC). This strategy beats the temptation we may all incur from time to time to hammer directly on the often overworked, overharried and underinformed Carrier Medical Director, which sometimes accomplishes less-than-positive results.

Such a system is not in place for all private payers, although they do often post similar policies on their company Web sites.
A Quick Aside About Evaluation and Management Coding:

With regard to evaluation and management (E&M) codes, a frequently asked question concerns the use of an E&M code for evaluations provided on the same day as a procedure. What follows is only my opinion (not ASA’s):

Medicare allows the use of the –25 modifier for those same-day evaluations. However, routine use of this technique every time a procedure is performed is not appropriate and is a possible audit-trigger. Its use should be reserved for those situations in which the E&M event was more than simply a confirmatory interaction prior to an already planned procedure. A good rule to follow is that E&M events should be billed only when the original management plan and decision are made, with all required documentation provided.

Example A:

After an initial consultation, a patient with L5 radicular pain is scheduled to come in every week or two over a period of three to six weeks for three lumbar epidural steroid injections (ESIs). Each time the patient comes in, the physician bills for a follow-up E&M event and an ESI, even though it was apparent that the decision to provide all three injections was made on the first visit. This is probably an incorrect use of the E&M code.

Example B:

On the other hand, perhaps that patient comes in for the second ESI and, after evaluation, the physician decides not to place another ESI because all the patient’s complaints were now axial, and the radicular component has resolved. Rather, after evaluation of the interim history and the current physical examination, the physician offers to provide facet injections that day. This is a new decision and is due to the response of the patient to the first injection as well as the current physical findings. In this situation, another E&M event has occurred and could be charged for if appropriately documented.

Another important resource is the evaluation and management documentation instructions available at <www.cms.hhs.gov/physicians/cciedits/default.asp>. This site lists all the edits associated with the National Correct Coding Initiative (NCCI). CMS subscribes to the NCCI, and so this site tells the viewer which codes are not to be used with which other codes and which codes are considered “bundled” with others. It is updated quarterly, and its information needs to be a regular part of your coders’ lexicon. You might also use it yourself when you are analyzing your denial reports and see that you are consistently being denied reimbursement for a certain procedure code.

Again, repeated use of these resources will help you to understand what your carriers and payers are using to determine your reimbursement. If what they are doing does not appear to be correct, try contacting your CAC or call the ASA Washington Office.

There also are a wide variety of quality conferences provided around the country to help physicians with the management of their practices. One of the best, if not the best, is put on by ASA every February — next year, the annual ASA Conference on Practice Management will take place in San Francisco, California, on February 4-6, 2005. I highly recommend it. (See page 25 of this NEWSLETTER for details.)

ASA and Future Challenges for the Pain Medicine Practitioners

The pain medicine practitioner faces increasing challenges to his or her efforts to practice high-quality, evidence-based medicine. A dearth of peer-reviewed literature that portrays the efficacy of many of the procedures that anesthesiologists provide puts us at a disadvantage in trying to convince payers that coverage of our work is warranted.

The good news is that ASA’s support means that the largest advocacy group concerned with pain medicine is at our disposal in presenting our case to payers. More good news is that, to further leverage its impact, ASA has now joined the Pain Care Coalition, a large and effective lobbying group.

All this help is great news for pain medicine physicians, but it cannot be emphasized enough that no matter how hard ASA works for you, you are your own best help. As an increasing number of practitioners crowd around a resource pie that seems ever smaller, pain medicine practitioners must aggressively monitor payer policies and their own individual treatment outcomes so that the therapies they believe in remain available to their patients. In that effort, however, it is reassuring that ASA leadership believes so strongly in the value of anesthesiologists as pain medicine specialists. ASA continues to provide a number of informed and dedicated pain physician experts who work hard to aid the excellent ASA staff in lobbying both governmental and payer policy makers to further aid pain medicine practitioners in the management of their practices.
It has been said that a picture is worth a thousand words, and I asked a patient of mine, a delightful grandmother, to tell her story so that anesthesiologists who do not commonly treat pain patients could see a “snapshot” of just one patient and the difference effective pain treatment made in her life. Any pain physician will have countless similar stories from his or her patients on any given day, so Jackie’s story is not meant to be extraordinary, but it is a common example of the work that pain physicians do every day. Recently the hospital CEO came to me at a party and told me how one of our patients told her that the treatment we had given him had “changed his life.” She was amazed and said, “I bet you don’t hear this often.” My comment was “No, in fact we hear this comment many times a week,” and indeed, so do my pain colleagues all across the country and across the world. I think she was surprised not only at the scope of pain practice but the positive results.

— Doris K. Cope, M.D.

Let me begin by saying that on February 4, 2004, I had an intrathecal pain pump implanted for control of severe back pain. This, by far, is the best treatment I have ever received. I’m doing things I never thought I would be able to do, and this has given me new excitement and hope for the future. In the two months since I had the implant, I have received eight times for bed rest, physiotherapy, traction and medication (pain pills and corticosteroids). Resting seemed to help while I was resting. As soon as I would return to my regular routine, the pain would return.

At the same time, I was advised by my obstetrician/gynecologist that if we wanted more children, I should do it soon because he felt that in another few years, I would need a hysterectomy. So we had our second child, a daughter, in 1965. After her birth, I started having more symptoms. I was dragging my right leg and had a lot more weakness on my right side. I had problems lifting my 3-year-old and infant. I finally went to see a neurosurgeon. More X-rays were done along with a myelogram. The diagnosis was a slightly slipped disc, nothing that could cause all the pain I was experiencing. The neurosurgeon recommended an exploratory laminectomy,
meaning he would go in and look around. If there was something to fix, he would fix it; if not, he would close me up. I was 26 or 27 and couldn’t lift my baby out of bed. I felt I had to try. My husband and I were both scared. The doctor had told us the odds, and they didn’t sound too good. The odds were:

1. No better, no worse than before surgery;
2. A little better than before surgery but not pain-free;
3. A lot worse than before surgery with the possibility of never walking again.

But I still felt I wanted to try to get rid of the pain that was keeping me from enjoying my children and my husband.

I had the surgery, and to everyone’s surprise but mine, I had a fully slipped disc on both sides of the spinal column. They did a fusion using cadaver bone, and the surgery was over. The surgeon came to talk to my husband and family. He apologized for not believing the level of pain I was experiencing. He confirmed I could not have moved without being in excruciating pain. He said he found a very old herniated and degenerated disk and literally just picked pieces of it out of my back. It was at that time that we figured out it must have been the accident. I had a good outcome with that surgery and eventually went back to work. I had 10 good years. Then in 1977, the pain returned on the right side of my back and the back of my right leg. This time it was scar tissue. So I had that removed. The surgeon ordered a brace to wear during the busiest parts of the day. Finally in 1980, I had a third surgery to remove more scar tissue. The scar tissue had crushed my sciatic nerve. At that time, they did a rhizotomy in which the back of my leg was supposed to get numb, but my luck had run out. The rhizotomy numbed the front of my right leg and I ended up with continuing pain in the back. It was at this time that they referred me to a pain clinic. I thought this was a temporary thing and that eventually I would be O.K. Shortly after starting at the pain clinic, I realized this is a long-term treatment clinic where they just try to make it more comfortable for patients with chronic pain. I was frustrated and depressed.

At the pain clinic, all kinds of nerve blocks were tried, starting with conservative treatment and ending with epidurals, caudals, nerve blocks with fluoroscopy, nerve blocks under anesthesia and radiofrequency treatments. Radiofrequency is a relatively new treatment that gave me a good result, but it didn’t last long enough to justify its use. I was lucky to get about three weeks’ relief while some patients got from six months to one year. There were side effects from all the medication. All the pain pills and all the muscle relaxants have side effects. I got early cataracts from the steroids I’ve taken off and on over the years. I also had a severe case of cellulitis that required two surgeries. So none of this treatment came without consequences. I’ve even tried a TENS unit.

With my new implant, I feel my pain is in control, and I feel that I have a new lease on life. I have walked around the lake I live on (two miles) two or three times, and I’m looking forward to walking some more. I also kept my grandchildren for four days recently (ages 5 and 2). I would have never attempted the babysitting until now. At the moment, I’m not taking any pain medication or muscle relaxants. This has reduced my drug bill quite a bit, also.

I want to thank my doctor, Doris K. Cope, M.D., Director of the Pain Clinic at St. Margaret’s Hospital in Pittsburgh for suggesting this mode of treatment for me. It has made a significant difference in my life, and I will be forever grateful. Her advancements in the care of people in chronic pain are outstanding, and her staff has been wonderful. They answer all my questions and have been very supportive.

— Jacquelyn A. Cowher, Chalk Hill, Pennsylvania
Robert K. Stoelting, M.D., to Receive 2003 Distinguished Service Award

James E. Cottrell, M.D., Chair
Committee on Distinguished Service Award

A highlight of this year’s ASA Annual Meeting will be the presentation of the Distinguished Service Award, our Society’s highest recognition, to Robert K. Stoelting, M.D., on Monday, October 25, just prior to the Emery A. Rovenstine Memorial Lecture at the Las Vegas Hilton. He was named the 2003 recipient of this prestigious award at last year’s Annual Meeting in San Francisco, California.

Dr. Stoelting matriculated as a freshman at Indiana University in Indianapolis in 1957, graduated from Indiana University School of Medicine in 1964, did his residency at the University of California School of Medicine-San Francisco and then served as a Clinical Associate in Anesthesia for two years at the National Institutes of Health in Bethesda, Maryland. Heading back to his roots, Dr. Stoelting joined the faculty of the Department of Anesthesiology at Indiana University School of Medicine in 1970 and became Professor and Chair of that department in 1977.

Dr. Stoelting has authored or co-authored more than 100 peer-reviewed publications, authored the textbook Pharmacology and Physiology in Anesthetic Practice, co-authored the textbooks Basics of Anesthesia and Anesthesia and Coexisting Disease and co-edited the textbook Clinical Anesthesia. He also served on the editorial board of Anesthesia & Analgesia from 1974-84 and was a member of the Board of Trustees of the International Anesthesia Research Society from 1975-93. He was a member of the editorial board of the Year Book of Anesthesia from 1983-94 and served as editor-in-chief of Advances in Anesthesia from 1982-92.

As a diplomate of the American Board of Anesthesiology, Dr. Stoelting participated in the Board’s certification process as an Associate Examiner from 1974-02. He was elected a Director of the American Board of Anesthesiology in 1980 and served as Secretary-Treasurer from 1989-91 and President in 1992. Dr. Stoelting was a member of the Residency Review Committee for Anesthesiology from 1983-89 and served as its Chair in 1988-89. He was appointed to the Anesthesia and Life Support Drugs Advisory Committee of the Food and Drug Administration in 1984 and served as that committee’s Chair from 1986-88.

In 1994, Dr. Stoelting was elected ASA Vice-President for Scientific Affairs. He was re-elected to this office in 1995 and 1996. In 1997, Dr. Stoelting was elected President of the Anesthesia Patient Safety Foundation (APSF), and on June 30, 2003, he retired as Chair of the Department of Anesthesiology at Indiana University School of Medicine to serve full-time as APSF President in Indianapolis, Indiana.

My own appreciation of Dr. Stoelting’s contribution to anesthesiology gelled at his 1990 Rovenstine Memorial Lecture. The take-home message was that we should never lose our zeal for being students. Reading selected papers from Dr. Stoelting’s curriculum vitae made me his student — it rekindled my interest in basic physiology, refreshed my knowledge of fundamental concepts and taught me a thing or two that were brand new.

For example his 1969 paper with Edmond I. “Ted” Eger II, M.D., on second gas effect is a classic — a simple, elegant, original and empirically verified explanation of why the alveolar concentration of a less soluble gas, halothane, for example, rises at a faster rate when it is given on top of a more soluble gas such as nitrous oxide than when it is given alone. The key here is Dr. Stoelting’s “concentrating effect” — one of those ideas that is so simple and so clearly correct that I found myself saying, “I could have thought of that.” Of course I did not, and neither did anyone else. In a similar vein, again as Dr. Eger’s resident, Dr. Stoelting figured out the relationship between anesthetic gas solubility

Continued on page 20
Clifford J. Woolf, M.D., Ph.D., Named Recipient of 2004 Award for Excellence in Research

Warren M. Zapol, M.D.

In a corner of the Boston Public Garden stands a tall neogothic monument commemorating the demonstration at Massachusetts General Hospital (MGH) on October 16, 1846, by William T.G. Morton, that inhaling ether produces a reversible state of insensibility during surgery. The monument carries a quotation from the Book of Revelations: “Neither shall there be any more pain.” Unfortunately that dream was not realized in 1846 and remains a dream to this day. Clifford J. Woolf, M.D., Ph.D., has dedicated his professional career to dissecting out the physiological and biochemical mechanisms of pain sensation in what he passionately maintains is the essential first step in promoting a rational basis for the effective management of pain. He has done this with persistence, flair, imagination and innovation.

A native of South Africa, Dr. Woolf became a medical student in Johannesburg in the early 1970s at the height of the apartheid government’s power. Dr. Woolf was immediately confronted with the limitations of an empirical approach to analgesia. He undertook studies of transcutaneous electrical nerve stimulation and completed M.B., Ch.B. and Ph.D. degrees at the University of Witwatersrand, Johannesburg, South Africa. Following training in medicine, he emigrated to London with his wife, Fredia, where he held medical and research posts at Middlesex Hospital and later University College London (UCL). There Dr. Woolf was fortunate to study under the tutelage of Professor Patrick D. Wall, the undisputable giant of the pain field and the co-discoverer of the spinal gate control theory.

In this innovative laboratory, Dr. Woolf went on to discover an important phenomenon that has become known as “central sensitization.” Dr. Woolf worked hard to show that the phenomenon could be detected in dorsal horn neurons, involved activation of N-methyl-D-aspartate receptors, was reduced by opiates and contributed to tactile allodynia and secondary hyperalgesia. Nevertheless he continued to face skepticism about its clinical significance, which stimulated him to collaborate in clinical trials on the relative merits of morphine analgesia given before or after surgery in an attempt to prevent or pre-empt central sensitization. It now seems difficult to believe, but at that time, there was enormous resistance from anesthesiologists and surgeons to administering an analgesic until a patient complained of severe pain. It is one of Dr. Woolf’s major achievements that many now recognize that treating pain early is both scientifically valid and ethically essential. He eventually became a Professor of Neurobiology at UCL.

In 1997 I recruited Dr. Woolf from a chilly laboratory in London to Boston where he became the first incumbent of the Richard J. Kitz Chair of Anesthesia Research at Harvard Medical School and Director of the Neural Plasticity Research Group in the Department of Anesthesia and Critical Care at MGH. The attraction was twofold: an opportunity to retool his laboratory in a much more molecular biological direction and to be part of MGH’s ongoing commitment to translating science from bench to bedside.

During the time that Dr. Woolf has been at MGH, he has consolidated his new laboratory into one of the major centers of pain research in the United States. His research team has exploited subtractive hybridization and microarrays to reveal that hundreds of genes are regulated in pain-related conditions in dorsal root ganglion and dorsal horn neurons and has shown that some of these genes are likely to be the targets for completely new classes of analgesics. His laboratory has participated in the cloning of a novel nociceptor sensory neuron-specific sodium channel, defined the intracellular signaling pathways and ion channel/receptors that mediate central sensitization and revealed that cyclo-oxygenase 2 is...
and rate of recovery from anesthesia, another obvious-once-you-think-about-it kind of idea whose time had come but whose vehicle for discovery had just arrived.

I do not have space to mention even a substantive fraction of Dr. Stoelting’s many articles and book chapters, but let me describe just one more because of its unique design. When Dr. Stoelting and his colleagues wanted to find out if it mattered whether protamine is administered by a five-minute infusion or by rapid injection at the conclusion of cardiopulmonary bypass, they faced an ethical dilemma. They believed, and it turned out correctly so, that rapid injection would jeopardize their patients. Dr. Stoelting again came up with an ingeniously obvious solution: six patients and 12 dogs. They gave the people and the first six dogs a five-minute infusion, got exactly the same benign hemodynamic result and then gave the second set of dogs a rapid injection, obtaining a clear and clearly deleterious hemodynamic effect.

The only difficulty with giving the Distinguished Service Award to Robert K. Stoelting at this juncture in his career is that his future contributions as APSF President may warrant yet another Distinguished Service Award before he actually retires. But never mind — we will decide how to handle that in 2024!

Robert K. Stoelting, M.D., to Receive 2003 Distinguished Service Award

Continued from page 18
ASA is proud to announce the winner of the 2004 ASA Presidential Scholar Award, H. Thomas Lee, M.D., Ph.D. Dr. Lee is currently Assistant Professor of Anesthesiology at the College of Physicians and Surgeons of Columbia University in New York City. He graduated from New York Medical College (M.D., Ph.D., physiology with honors) in 1994, having already received an engineering degree from the University of Michigan in Ann Arbor.

After two years as a graduate teaching assistant in the Department of Physiology at New York Medical College, Dr. Lee trained as a resident in the Department of Surgery at Stanford Medical Center in Palo Alto, California. From 1996-99 he trained as a resident in the Department of Anesthesiology at Columbia, completed a post-doctoral research fellowship in that department and joined the faculty in December 2000. During his fellowship Dr. Lee entered the National Institutes of Health (NIH) T32 training program where he focused on ischemic preconditioning in the kidney.

Dr. Lee’s research has elucidated the protective roles of preconditioning and adenosine receptor modulation against renal ischemic reperfusion injury. He also has investigated modulation of renal protection by local and inhalational anesthetics. Using multiple molecular and biochemical approaches as well as in vivo techniques to better understand both injurious and protective signaling pathways, Dr. Lee’s current research focuses on signals that send some cells to necrotic, and others to apoptotic, cell death.

To date, Dr. Lee has published 26 papers in basic science and clinical journals. He has received numerous awards for his work, including first prize at the Postgraduate Assembly of the New York State Society of Anesthesiologists in 1999 for his Resident Research Contest entry, and he was a finalist for the Vivian Thomas Young Investigator Award at the American Heart Association Annual Meeting in Atlanta in 1999. Dr. Lee wrote his first NIH R01 grant during the second year of his anesthesiology research fellowship and received NIH funding the day he joined the faculty at Columbia as an assistant professor.

Dr. Lee’s clinical practice is primarily devoted to anesthesia for vascular surgery, where he is recognized as an outstanding clinician. He has provided a collaborative link between the Department of Anesthesiology and other clinical and basic science departments at Columbia University.

The ASA Presidential Scholar Award was initiated in 2003 “to stimulate scientific advancement by recognizing colleagues who dedicate their formative careers to research” (January 2003 ASA NEWSLETTER). Like Peter J. Provonost, M.D., Ph.D., before him (Anesthesiology 100:216-217), Dr. Lee is an exemplary Presidential Scholar. The award will be presented prior to the Emery A. Rovenstine Memorial Lecture during the ASA Annual Meeting on October 25, 2004, at the Las Vegas Hilton. Dr. Lee will present his research, along with presentations by the winner of the Award for Excellence in Research and the first-place winner of the Residents’ Research Essay Award, at the Celebration of Research Symposium, moderated by Michael M. Todd, M.D., Editor-in-Chief of Anesthesiology, following the Rovenstine Lecture. The Celebration of Research will take place from 12:30 p.m. to 2 p.m. on Monday, October 25, at the Las Vegas Hilton.

Recipients of the Presidential Scholar Award receive a plaque to acknowledge their achievement and an opportunity to present their papers at the awards ceremony and as an oral scientific poster presentation at 8 a.m. on Sunday, October 24, during the House of Delegates meeting in the Las Vegas Hilton.

James E. Cottrell, M.D. is Chair, Department of Anesthesiology, Downstate Medical Center and Distinguished Service Professor, State University of New York, Brooklyn, New York. He is ASA Immediate Past President.
House of Delegates to Convene October 24, 2004: NEW TIME

Candace E. Keller, M.D.
Speaker of the House of Delegates

The 2004 House of Delegates and reference committee hearings will be held at the Las Vegas Hilton Hotel, Las Vegas, Nevada, on Sunday and Wednesday, October 24 and 27, 2004. Times and locations of these meetings will be listed on the hotel bulletin board. All ASA members are invited to attend and participate in the reference committee hearings during which items before the House of Delegates will be presented. All Delegates and Alternate Delegates are urged to attend both sessions of the House as well as their assigned or chosen reference committees.

Special Schedule!
The ASA President has appointed a special fifth reference committee this year to hear testimony on the reports of the Task Force on Payment Methodology. These reports will appear in the handbook as 625-1, 625-2 and 625-3. It is anticipated that these reports will be of considerable interest and importance to ASA members. Therefore our Sunday schedule will be altered to provide ample opportunity to conduct the business before the House and reference committees in an efficient and orderly manner. Please note: the first session of the 2004 House of Delegates will begin on Sunday, October 24, 2004, promptly at 8 a.m. The special Reference Committee 5 hearing will begin at 12:30 p.m. There will be a brief five-minute recess at 1:50 p.m. of Reference Committee 5 to allow those members who wish to attend the hearings of the other four committees to exit. Other reference committee hearings will be held concurrently and begin at 2 p.m. in their designated locations. Open hearings will continue this year until 4 p.m. or until testimony has concluded, whichever is later. Hearings must adjourn or recess no later than 5 p.m. and will reconvene at 8 a.m. on Monday morning only if necessary.

Our ASA Legislative Process
The voting members of the ASA House of Delegates are elected to represent the various constituencies of the entire ASA membership, including state component societies, resident and fellow components, the military and academic components and specialty societies. There is one voting member for every 100 ASA members in a state component society. In addition to electing these representatives, each component elects a Director who serves on the Board of Directors and a voting member of the House of Delegates. The legislative process permits these members of the House to hear the facts, give proper consideration to every item before the House and debate and vote on these items in an open and deliberative democratic assembly.

A Handbook for Delegates containing meeting materials is mailed to Delegates and Alternate Delegates in advance of the meeting. These materials constitute the agenda for the House of Delegates. The sources of these business items include reports from the officers, component directors, committee chairs, task force chairs and resolutions from individual delegates. Each item is referred to a reference committee by the Speaker of the House. Lack of familiarity with the Handbook for Delegates is likely the biggest obstacle to participation in these deliberations. ASA officers, particularly the Speaker and Vice-Speaker, and ASA staff are eager to provide needed assistance to any member regarding how to use the handbook to find issues of interest. The House of Delegates Office will be located at the Las Vegas Hilton Hotel during the 2004 Annual Meeting and is the best place to obtain such assistance.

The first session of the House of Delegates will convene on Sunday at 8 a.m. (in previous years, the House had convened at 9 a.m. on Sunday). ASA President Roger W. Litwiller, M.D., and President-Elect Eugene P. Sinclair, M.D., will present their remarks at this session, followed by the nomination of officers, candidate speeches to the House. The House is recessed following conclusion of the Sunday morning agenda.

Sunday afternoon at the reference committee hearings provides the best opportunity for individual members to comment on any issue coming before the House. The reference committees are composed of seven members and are appointed by the President with consideration to geographical distribution and experience regarding the issues and processes of the House. Although discussion is rarely curtailed at reference committee hearings, members are encouraged to present their remarks succinctly and respectfully. All remarks are directed to the Chair; debate between refer-
ence committee attendees is not permitted. The reference committees then go into closed (executive) session to decide their recommended action on each item of business assigned to them. The written reports of the reference committees’ recommendations are usually available by 5 p.m. Tuesday in the House of Delegates Office.

The second session of the House of Delegates will convene at 8 a.m. on Wednesday, October 27. Election of officers is typically the first agenda item; the House then proceeds to other business. The time of adjournment cannot, of course, be anticipated. Usually the reference committees provide ample opportunity for discussion and will have responded with appropriate and broadly acceptable recommendations for action. Formal parliamentary procedure is used to dispose of the recommendations and any motions, amendments, referrals or other such action the House may desire to take under the direction of the Speaker and Vice-Speaker. Members are strongly urged to consider the volume, nature and potential amount of debate that may occur on Wednesday when making their departure reservations, particularly this year.

New Delegates, Alternate Delegates or any member with questions regarding procedure might wish to avail themselves of several specific sessions. A new delegates’ briefing will be conducted by the Speaker and Vice-Speaker from 9 a.m. to 10 a.m. on Saturday and is open to any interested member. The hour consists of an introduction to the Handbook for Delegates, ASA Annual Meeting processes and a brief overview of parliamentary procedure. The Speaker and Vice-Speaker also will be available during the Speakers’ office hour on Tuesday evening to discuss any procedural issues or questions with regard to reference committee reports to be presented at the Wednesday session of the House. Any member planning to introduce substantial or potentially controversial amendments are encouraged to discuss these with the Speaker and/or Vice-Speaker in advance so that all business may be conducted in an efficient, fair and impartial manner.

Finally it is highly recommended that all members attend the meetings of their respective geographical caucuses. There are a number of unofficial but well-organized caucuses that typically meet on Saturday and/or Tuesday afternoons at the Annual Meeting. At these caucuses, issues and candidates are discussed in free and open discussion (sometimes more open than in the House because of the smaller size and more informal atmosphere). The meeting locations and times will appear in the House of Delegates Handbook and also will be posted in the House of Delegates Office.

As of July 15, 2004, visitors to Las Vegas were given the option of getting around The Strip on the world’s most advanced public transportation system, the Las Vegas Monorail. This $650-million rail system runs the entire length of The Strip and costs only $3 per person one way and $5.50 for a round trip.

This state-of-the-art, driverless, electric rail system is expected to ease congestion around Las Vegas’ busiest attractions and offer a safe, quick and convenient transportation option to visitors. The monorail reaches speeds of up to 50 miles per hour and can complete its entire four-mile route in as little as 14 minutes.

Station stops are located along the four-mile route at the Sahara Hotel and Casino, Las Vegas Hilton, Las Vegas Convention Center, Harrah’s/Imperial Palace, the Flamingo/Caesars’s Palace, Bally’s/Paris Las Vegas and the MGM Grand. Tickets can be purchased at vending machines located inside each station and at station properties.

The monorail will run 365 days a year from 6 a.m. to 2 a.m. Each air-conditioned train seats 72 riders with standing room available for an additional 152 riders. Almost 20 million people are expected to use the system each year.

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New Educational Activities Scheduled for Annual Meeting

Arnold J. Berry, M.D., Chair
Task Force on Annual Meeting Opportunities

When members planning to attend the ASA Annual Meeting review the 2004 program, they will notice several new sessions, including two subspecialty learning tracks and a plenary lecture. These additions were recommended by the Task Force on Annual Meeting Opportunities, a group constituted to evaluate the structure and content of the Annual Meeting and to ensure that ASA offers the most effective educational activities to meet the needs of its members. After an analysis of the structure and content of the meeting, the task force recommended a trial of concentrated educational programs devoted to clinical subspecialties.

Critical care medicine and obstetric anesthesia were selected for the content of the initial tracks. The task forces that planned the two educational tracks consisted of representatives from ASA and the respective subspecialty societies, the American Society of Critical Care Anesthesiologists (ASCCA) and the Society for Obstetric Anesthesia and Perinatology (SOAP). Each track will be presented over a two-day period and will include both traditional (refresher course lectures and panels) and innovative educational sessions (pro/con debates, oral scientific paper presentations). The goal of the tracks is to offer an integrated program for anesthesiologists who desire a more in-depth focus on content within the subspecialty area. The two tracks will take place within the Annual Meeting, and, therefore, attendees can participate in the entire two-day track or can choose to mix portions of the tracks with the other concurrent educational offerings.

The critical care track, planned by a task force chaired by Neal H. Cohen, M.D., will take place on Saturday and Sunday. The sessions will focus on the care of critically ill patients and will include topics such as central nervous system resuscitation, fluid management, glycemic control and transfusion therapy. Scientific paper presentations on critical care will be included within the track and will be grouped into sessions covering outcomes and safety, sepsis and inflammation, and patient management. The ASCCA/Anesthesiology Special Session will be held on Saturday morning within the critical care track. Scientific papers will be selected for presentation along with commentary from the researcher’s mentor. This session offers an opportunity to learn about cutting-edge research in critical care medicine and to interact with the investigators. The track also will provide additional educational opportunities, including panel discussions, poster-discussion sessions and a number of debates on important issues in patient management.

The obstetric anesthesia track, planned by a task force chaired by David J. Wlody, M.D., will take place on Monday and Tuesday. Beginning on Monday with the Sol Shnider SOAP Breakfast Panel “New Horizons in OB Anesthesia,” the track will contain sessions covering new concepts in obstetric anesthesia. Each morning, refresher course lectures will be offered concurrently with scientific abstract poster presentations. Afternoon sessions consist of panels such as “Regulatory Issues in OB Anesthesia,” a clinical forum and a debate titled “Masks Should Be Worn During Neuraxial Anesthesia.” For individuals who attend only the weekend portion of the Annual Meeting and would be unable to attend the obstetric track, there will be several obstetric refresher course lectures held as part of the traditional Refresher Course Lectures on Saturday and Sunday. These refresher courses will provide coverage of broader obstetric topics.

Since the tracks represent a new approach to the design of the meeting, the Task Force on Annual Meeting Opportunities is most interested in evaluating the effectiveness of this concept. Questionnaires will be available for attendees to voice their opinions regarding the sessions within the tracks and the overall value of the tracks in their educational experience. If the initial two tracks are positively received, the task force plans to expand the number of tracks offered at future meetings with a long-range goal of including tracks for all subspecialties recognized by ASA.

Discussions within the task force also focused on the rapid advance of cellular and molecular research and the need to highlight the relevance of recent discoveries to the clinical practice of anesthesiology. Therefore a new plenary session is being introduced to focus on translational topics. Louis J. Ignarro, Ph.D., is one of three individuals who shared the Nobel Prize in 1998 for the discovery of nitric
Each year ASA sponsors a Conference on Practice Management. Usually held the first weekend in February, it brings together anesthesiologists, administrators, consultants and regulators to review the business of anesthesiology. Speakers cover economic, professional, marketplace, regulatory and organizational aspects of the specialty.

The Conference on Practice Management rotates among cities, most recently in San Antonio, Texas, La Jolla, California, and Ft. Lauderdale, Florida. The 2005 conference will meet in San Francisco, California, at the Grand Hyatt Hotel, February 4-6. Structuring the conference for audience participation and break-time networking means limiting attendance to 400 to 500 people. Since the conference usually sells out, early registration is desirable. Information will first appear on the ASA Web site in October.

Speakers at the 2004 conference included 11 anesthesiologists, three lawyers, two practice administrators, one business consultant and one federal regulator. Most of the anesthesiologists lead large groups or have business degrees; all have information useful for anesthesiology practices. New at the 2004 conference was a session with discussion tables that was led by speakers and practice management committee members. Attendees rated the small-group discussions very highly, and we will repeat this in 2005. Table 1 (page 26) shows the 2004 discussion table topics, and Figure 1 (above) portrays the collegial and interactive format.

The Committee on Practice Management oversees the organization of the conference. Committee members seek the best speakers on the hottest topics and carefully consider how attendees rated presentations at the most recent conference. Proving particularly popular in 2004 were Judith J. Semo, Esq., speaking on “Hospital Stipend Negotiation,” Ann S. Lofsky, M.D., on “Medical Malpractice Insurance,” and Alexander A. Hannenberg, M.D., on “The Future of Payments for MAC and Sedation Services.”

Ms. Semo, a lawyer with Squire, Sanders & Dempsey in Washington, D.C., is known to anesthesiologists as the primary author of “Starting Out: A Practice Management Guide for Anesthesiology Residents.” In her talk, she related that “increasing financial pressures, combined with a shortage of anesthesiologists and nurse anesthetists, have forced many anesthesiologists to seek financial assistance from the hospitals at which they practice.” She offered advice on how much assistance to request, how to structure the payments and how to negotiate the arrangement.

Dr. Lofsky, a California anesthesiologist and director of the Doctors Company, discussed how malpractice liability insurers view anesthesiologists and provided some industry statistics. Only 8 percent of death claims result in indemnity payments, but these payments average $225,000 to the decedents’ families. The indemnity for brain damage cases averages $630,000 per claim paid. Two emerging areas of risk are ischemic optic neuropathy and sleep apnea after postoperative narcotic medication.

Continued on page 26
Dr. Hannenberg, ASA Vice-President for Professional Affairs, reviewed the rise of medical necessity policies due to concerns by payers about the legitimacy of monitored anesthesia care services. He also described an increasing interest in anesthesiologist-administered sedation, especially for endoscopy, but without consensus on how to pay for it. Comparing the fees resulting from reporting sedations under anesthesia codes with those for the underlying procedure shows wide variances ($57 versus $420 in one example) that anesthesiologists should understand. He predicted changes in coding and payments for procedure sedations.

Other popular talks that illustrate the breadth of topics include “Practical Issues in O.R. Management,” “Understanding the Hospital/Anesthesia Group Relationship,” “Calculating the Cost of Covering a New Facility,” “Measuring Clinical Productivity for Anesthesiology” and “Academic Practices: Getting From Surviving to Thriving.” Conference speakers are generally adept and colorful. Some quips heard at the 2004 conference included:

- “The trouble with being punctual is no one’s there to appreciate it.” — Vinod Malhotra, M.D.
- “You may have a practice management problem if: Your administrator is unsure whether to run off with the accounts receivable or payable…” — Robert E. Johnstone, M.D.
- “When a weatherman’s predicting snow, it doesn’t mean he likes it.” — Alexander A. Hannenberg, M.D.

Primary goals for the conference are to educate and inform anesthesiologists. Pricing for the conference is modest at $325.

**Certificate in Business Administration (CBA)**

The Committee on Practice Management also oversees the CBA program. This very successful program held an alumni reception at the 2004 conference and organized a plenary session panel. Panelists debated how best to respond to a hospital request for proposals for anesthesiology services. George E. Gratzick, M.D., a South Carolina anesthesiologist, told a gripping story of unwanted crisis management when it happened at his hospital. The CBA program costs $3,500 and has 66 physicians enrolled this year. Asa C. Lockhart, M.D., directs the program and plans to make the CBA alumni reunion an annual event.

Registration for both the Conference on Practice Management and CBA program opens each year at the Annual Meeting.
Since its establishment, the Foundation for Anesthesia Education and Research (FAER) has provided more than $10 million in support for education and research to more than 400 individual anesthesiologists. FAER continuously evaluates the results of its efforts, and, in 1987, a survey of past FAER grant awardees was conducted which demonstrated that recipients of FAER awards had successfully acquired additional peer-reviewed grants exceeding 11 times the dollar amount provided by FAER. Additionally the survey showed that more than 80 percent of FAER awardees had remained in academic practice. A new survey is currently under way.

The Grants

FAER annual awards have increased in amount from an initial $3,000 to as high as $140,000 for a current mentored Research Training Grant. The research awards are structured into three categories: Research Fellowship Grant, Research Starter Grant and Research Training Grant. They each differ as to eligibility, time commitment and amount of funding. The one-year, $50,000 Fellowship Grant is offered to anesthesiology trainees who also take the American Board of Anesthesiology (ABA)-allowed opportunity for six months of research activity (Clinical Scientist Track) during their clinical residency and do so in continuity with the one-year FAER grant. The two-year Starter Grant funds $35,000 the first year and $50,000 the second and is available to assistant professors who will spend 40 percent of their time devoted to the FAER-funded research project. The two-year Training Grant also is awarded to assistant professors spending 80 percent of their time involved in their FAER research proposal with $75,000 support for the first year and $100,000 for the second. The time commitment for mentoring, a principal expectation for the training grant, has led FAER to provide a $40,000 annual stipend to the mentor for the duration of the grant with the expectation of a minimum of 40 percent nonclinical time devoted to research. Research applications submitted to FAER are subjected to a very rigorous review process by the ASA Committee on Research that utilizes defined objective criteria mutually agreed upon by the committee and the FAER board.

FAER also provides support to education research in the form of a two-year Research in Education Grant to examine, evaluate and develop innovative educational programs. This grant replaces the former Education Grant; it provides a two-year award of $50,000 annually and is available to faculty at any level of seniority. Research in Education grants are subjected to a similar rigorous review by FAER’s Committee on Education Grant Review. Awarding of all FAER grants is widely recognized for fairness, integrity and excellence of the funding mechanism. The current budget for FAER includes an annual expense of $2,400,000 for these awards. FAER recognizes the essential need to disseminate new information as a necessity to advance our specialty as we incorporate new knowledge into clinical practice.

Importance of Mentors

It has become increasingly evident that the success of FAER’s efforts can only be realized if a mentoring capability exists at the local level to encourage, direct and supervise the awardee in her/his research project. Without the guidance of an experienced, successful and motivated research mentor, the young trainee will not achieve the goal of becoming an independent investigator capable of competing for peer-reviewed research funding from the National Institutes of Health and other sources. Therefore, in its newly revised award structure, FAER has placed increased emphasis on mentoring as a requirement for the award. It also is recognized that the time and effort required for research mentoring and training create an additional need for faculty funding from nonclinical sources; thus FAER has included financial support for mentors as part of its mission. FAER also has established an Academy of Mentors in recognition of the extraordinary contribution of highly successful mentors. This new organization exists not only to provide recognition for outstanding contributors to the training of future anesthesiologists but also to provide a forum for sharing research experiences and mentoring strategies between faculty.

Ensuring Anesthesiology’s Place in the 21st Century: A Time for Growth or Obscurity — A FAER White Paper, Part 2

Myer H. Rosenthal, M.D., Chair
Foundation for Anesthesia Education and Research

Part 1 of this article appeared on page 36 of the July 2004 ASA NEWSLETTER.

Myer H. Rosenthal, M.D., is Professor of Anesthesiology, Medicine and Surgery, Stanford University School of Medicine, Stanford, California.
investigators but also a forum to discuss and develop implementation strategies to increase the numbers and effectiveness of mentors in our specialty.

Support for FAER is derived from the generosity of ASA, the anesthesiology community, including individual anesthesiologists, subspecialty and component societies, the Association of University Anesthesiologists (AUA) and donations from medical corporations. In 2003 the Foundation received $1,884,558 in donations from these sources. The major donor continues to be ASA with an annual commitment of $1,050,000. ASA continues to demonstrate commitment to the academic community and its recognition of the essential need to continue to develop new knowledge and educational activities to sustain anesthesiology’s major role in the future of medicine. Reliance on corporate donations has become increasingly difficult with the downturn in the economy and the mergers and consolidation of many companies.

If FAER is to be able to maintain its mission for individual career development and to increase its role in the growth of a vigorous mentoring program with a more widespread distribution of research activity, it must begin to assess alternative funding opportunities and to become more aggressive and innovative in encouraging support from the anesthesiology community at large. FAER has and will continue to recognize the need to increase its administrative support both in space and personnel as well as seek the advice of consultants and establish a development program staffed by experienced individuals with demonstrated success in soliciting contributions from various sources.

**Obscurity or Prosperity?**

If we do not expand our influence beyond the operating room, if we do not aggressively support the acquisition of new knowledge, if we are unable to advance the science of our specialty and if we allow our academic programs to do little more than provide clinical service and function only as a training ground for clinical anesthesiologists, we have clearly committed anesthesiology as a medical specialty to eventual obscurity. We must be committed to more than simply maintaining economic survival. Although such an approach may provide security for the present, it will only lead to an abrogation of our responsibility for the future and become testimony to the lack of appreciation of the necessity for our contribution as physician specialists in anesthesiology. None of us wishes to be remembered as having failed to provide the necessary environment for physician anesthesiology and having brought about its extinction by our inaction.

Renewed interest in anesthesiology as a career by medical students, the availability of competitive funding for established investigators and the recognition of the necessity to focus on scientific productivity as the key to the growth of physician-led anesthesiology present major opportunities for progress and growth of this medical discipline. Deficiencies are evident, but enthusiasm for change is present among the academic and political leaders in our specialty. FAER, ASA and other academic societies and related organizations need to demonstrate enthusiastic leadership and provide direction as motivators and supporters of this effort.

FAER-sponsored retreats among the leaders of major anesthesiology organizations took place in August 2003 and June 2004. The results of these two-day meetings were the development of implementation strategies to enhance the growth and contributions of academic anesthesiology. The demonstrated enthusiasm and dedication of the participants at the retreats and the recent establishment of an ASA Committee on Academic Anesthesiology have created a sense of optimism for the exciting opportunities that exist for the prosperity and future success of our academic programs and our specialty.

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**New Educational Activities Scheduled for Annual Meeting**

*Continued from page 24*

oxide and its role in vascular regulation. Dr. Ignarro will speak on “Nitric Oxide as a Unique Signaling Molecule in Biology” on Tuesday, October 26, from 12 noon to 12:50 p.m. at the Las Vegas Hilton. Nitric oxide is one of the simplest molecules in nature, but it participates in multiple physiologic processes, including vasodilation, antiplatelet effects and neurotransmitter functions. Both nitroglycerin and sildenafil (Viagra®) produce their clinical effects through nitric oxide. Currently serving as Professor of Molecular and Medical Pharmacology at the University of California-Los Angeles, Dr. Ignarro continues his research on the regulation, production and functions of nitric oxide. His presentation will be a wonderful opportunity to learn from an internationally recognized scientist about a simple molecule that has diverse effects and plays an important role in our clinical practices.

The Task Force on Annual Meeting Opportunities hopes that you will participate in these new offerings and will be most interested in learning whether they enhanced the value of your educational experience.
Has your group developed a formal system for evaluating the performance of individual anesthesiologists? Anesthesia Administration Assembly member David Whitten, CEO of Anesthesia Medical Group in Nashville, Tennessee, describes the process used by his very large group below. Implementation of this sophisticated process would require much adaptation by smaller groups, but we hope that the basic concepts and findings will be of interest to all.

We have used a simple tool for several years now in evaluating our anesthesiologists. (We have a different system for evaluating our nurse anesthetists.) We are a large practice arrayed in five call pools of varying sizes. The evaluations are done under a peer-review blanket and thus protected. [Satisfying the statutory conditions for peer review will generally shield performance information from discovery in litigation. — K.B.]

Once a year, the anesthesiologists in a call pool evaluate each other on five questions:
• Clinical skills
• Customer service
• Work ethic
• Nurse anesthetist relationships
• Ability to work as a team member

Each question is ranked on a scale of 1-7. We use an outside firm to tabulate the results. Each anesthesiologist is profiled on each question against the call pool mean. The call pool chief visits with every physician to review that physician’s results. Any anesthesiologist falling two standard deviations or more from the call pool mean is re-evaluated in six months. Counseling (for problems of team member and nurse anesthetist relationships, for instance) and remedial courses, as appropriate, are strongly encouraged. These are on the physician’s time and at his or her expense. Failure to correct the deficiency is dealt with by a visit with the board of directors.

If a physician falls two standard deviations below the mean for two years in a row, the consequences are:
1) Visit with the board;
2) Mandatory remedial course; and
3) Formal review after six months.

In addition we believe clinical skills and customer service are the top priorities. Therefore, if an anesthesiologist falls two standard deviations below the mean in two sequential years on either or both of those questions, he or she may not be allowed to take call and thus sacrifices call pay for 90 days. Failure to correct the problem in a subsequent year will result in further penalties.

This entire effort is a work in progress and is only in its third year of use. The board and group have had to get comfortable with the process, its confidentiality, the benefit of honesty in their evaluations of each other and the need for firm, predictable and consistent consequences. This last point, the penalties, has been and is the most difficult to work our way through.

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2005 RVG and CROSSWALK™ Will Be Available in November

The 2005 Current Procedural Terminology-4™ codes become effective January 1, 2005. Unlike its practice in past years, the Centers for Medicare & Medicaid Services will not accept 2004 codes after that date. The 90-day grace period at the start of the year has been eliminated. Because of this, ASA is committed to publishing the 2005 editions of the Relative Value Guide (RVG) and CROSSWALK™ early so that users will be able to update their systems in order to switch over to the new codes on January 1, 2005. (Please note: you should not make this change effective before January 1. You must use the code set in effect on the date the medical service is provided.)

The 2005 editions of the RVG and CROSSWALK™ will be available in November. The Reverse CROSSWALK™ will be available only on CD. Order your copies from the ASA Publications Department at (847) 825-5586 or at <publications@ASAhq.org>.
As a practice administrator, my belief is that it is our job, as the group’s conscience and manager, to make sure that the process and results are consistent with the culture and values of the group. In my group’s case, we are constantly looking for better ways to do things in terms of clinical skills, customer service, relationships with nurse anesthetists, etc. I have said to the group, “If we are not looking to make things better, things will get worse.”

Doctors have no special training in evaluating peer performance and thus are often somewhat skittish about doing it. Sometimes they have to be encouraged and shown how to do it. Eventually they come to see the value. I remind them that I evaluate all staff members who report directly to me, and all of my direct reports evaluate their staffs. There is no fanfare or magic here — just letting people know how they are doing. Even physicians need this. The board and group have now begun to see the benefits.

I have asked that the board evaluate me formally each year; this is not something that the members were necessarily eager to do (nor I necessarily to endure). I believe that it is important that the board exercise its duty to the shareholders to make sure I am doing my job.

Lessons learned:
1. Physician evaluations help to make the group better.
2. Physicians may need to be shepherded gently through the process, and it takes years for performance evaluation to become part of the culture of the group.
3. The administrator may have to drive the process for a while.
4. Confidentiality and nondisclosure are essential.
5. The anesthesiologists did not like my seeing the results the first time we went through the process. There is less concern that I see them now, and I am very careful in my use of the results.
6. Consistent, predictable and rational consequences are crucial.
7. Objective data interpretation is important. This is why I outsourced that function (but within the United States!).
8. Keep it simple. This is really important.
9. The anesthesiologists, for the most part, are able and willing to evaluate each other.
10. There will be some people who are upset. This comes with the process.
11. Behaviors and performance will change. For some anesthesiologists, it will be permanent. For others, it will not. With this latter cohort, the group has to be willing to accept that some of its members just will not get it. We are still struggling with this piece.

The Centers for Medicare & Medicaid Services (CMS) has been working hard for some time to provide better and more accessible information to physicians. One of the possible innovations that CMS discussed with the specialty societies was creating specialty-specific pages on the Web site. We are the first specialty to have worked with CMS on this project, which recently launched the Web page pictured to the right <www.cms.hhs.gov/physicians/anesthesiologist/default.asp>.

The page on “Medicare Information for Anesthesiologists” contains the anesthesia conversion factors, Medicare’s base units for the anesthesia codes; the section from the Claims Processing Manual spelling out the rules for “Payment for Anesthesiology Services” (this is where readers will find all the rules on medical direction) and other information. It is a good portal to all published Medicare policies and regulations, many of which are important to billing staff, if deadly dull reading for anesthesiologists. We are currently working on adding material on pain medicine services.
Florida Licenses AAs; Louisiana Bans AAs

S. Diane Turpin, J.D.
Associate Director of Governmental Affairs

After a three-year legislative battle, Florida Governor Jeb Bush signed legislation into law to license anesthesiologist assistants (AAs) to practice in the state. The bill passed the Senate by a vote of 280-12 and the House by a vote of 74-39. As previously reported, the Florida Association of Nurse Anesthetists vigorously opposed the legislation, keeping it from passage in two previous legislative sessions. This legislation would not have succeeded had it not been for the tireless efforts by the Florida Society of Anesthesiologists.

The legislation licenses AAs to practice under the “direct supervision” of an anesthesiologist. “Direct supervision” is defined as “the on-site, personal supervision by an anesthesiologist who is present in the office when the procedure is being performed in that office, or is present in the surgical or obstetrical suite when the procedure is being performed in that surgical or obstetrical suite and who is in all instances immediately available to provide assistance and direction to the anesthesiologist assistant while anesthesia services are being performed.” An anesthesiologist may supervise two AAs at the same time, although the Board of Medicine may, by rule, allow an anesthesiologist to supervise up to four AAs after July 1, 2008.

The new law defines the scope of practice of AAs, which is similar to the scope of practice in other states where AAs are licensed. The Board of Medicine has begun its rulemaking procedures. Florida becomes the eighth state (joining Alabama, Georgia, Kentucky, Missouri, Ohio, South Carolina and Vermont) where AAs are specifically licensed to practice. AAs practice in other states pursuant to Board of Medicine guidelines or the delegatory authority of an anesthesiologist.

A three-year effort to license AAs in Louisiana ended not only in defeat of AA licensure but with a new law effectively banning AAs from practicing in the state. The first of its kind in the nation, this new law also includes what can only be described as a press release from the American Association of Nurse Anesthetists.

The text of the new law reads as follows:

(1) The Louisiana Legislature hereby finds that:
   Certified registered nurse anesthetists (CRNAs) have been selecting and administering anesthesia in Louisiana and the United States for over one hundred years.
   The specialty of nurse anesthesia was established in the late 1800s as the first clinical nursing specialty.
   Nursing took the lead in formalizing anesthesia prac-
   tice as a specialty and in providing for specialty educa-
   tion and credentialing in anesthesia practice. During
   World War I, nurse anesthetists trained both physicians
   and nurses to provide anesthesia services both at home
   and abroad.
   Nurse anesthetists alone provided the overwhelming
   majority of anesthetics up until World War II.
   Nurse anesthetists receive rigorous clinical and aca-
   demic training, requiring a bachelor’s degree from an
   accredited school of nursing and one year of profession-
   al nursing experience in an acute care setting prior to
   being considered for entrance to an accredited twenty-
   four to thirty-six month nurse anesthesia educational
   program.
   CRNAs administer the majority of anesthetics in
   Louisiana, and all of the anesthetics in many parts of the
   state.
   Multiple studies have demonstrated that CRNAs are
   safe, accessible, and cost-effective providers of anesthet-
   ics.
   CRNAs are critical providers of quality anesthesia
   services in the health care delivery system in this state.
   An adequate supply of CRNAs in Louisiana is vital to
   continued access to safe, cost-effective health care for the
   citizens of Louisiana.
   Anesthesiologist Assistants (AAs) are not presently
   authorized to train or practice in Louisiana and are only
   recognized in eight states.
   Less than six hundred AAs exist in the United States
   while over 30,000 CRNAs are licensed and authorized to
   practice in every state in the United States.
   CRNAs receive a much higher level of education and
   training than do AAs.
   After thirty years of existence, only two AA schools
   exist in the United States while there are ninety-nine
   CRNA schools.
   CRNAs are trained and legally authorized to adminis-
   ter all types of anesthetics in all settings while AAs are
   limited by the type of anesthetics they can administer and
   the settings in which they are authorized to perform their
   services.
   (2) It is hereby declared that CRNAs are an essential
   provider of safe, accessible, and cost-effective anesthesia
   care to the citizens of Louisiana. It is further declared
   that a sufficient supply of CRNAs in Louisiana is affected
   with the public interest. It is hereby declared to be the

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Contemporary anesthetic practice is associated with low perioperative morbidity and mortality. While research in areas such as genomics promise to improve patient care, investigating the impact of intraoperative care on functional recovery and long-term outcomes has shown that anesthesiologists have much more to contribute to the care of the perioperative patient. Studies have shown, for example, that administration of perioperative beta-adrenergic antagonists have beneficial effects long after the patient leaves the operating room. Recent studies in critically ill patients suggest that other aspects of perioperative care managed primarily by anesthesiologists, including ventilator management, antimicrobial administration and transfusion practice, are likely to affect patient outcomes as well.

Glycemic control in critically ill patients is actively being debated among intensivists and endocrinologists. Available data support an association between hyperglycemia and increased morbidity and mortality in many different surgical and medical populations. The link between hyperglycemia and poor outcomes led to studies designed to determine if management of hyperglycemia would improve patient care. The DIGAMI trial enrolled diabetic patients admitted with acute myocardial infarction and randomly assigned patients to intensive insulin therapy with intravenous insulin or to routine antidiabetic therapy. Intensive insulin therapy was shown to be associated with significantly reduced long-term mortality. This observation encouraged investigation in other patient populations.

A recent prospective, randomized trial in critically ill adult patients was stopped early due to a significant reduction in intensive care unit (ICU) mortality in those patients managed with intensive insulin therapy. In this trial, patients were randomized to intensive insulin therapy (goal glucose 80-110 mg/dl) or conventional therapy (treat for glucose > 215 mg/dl, maintain 180-200 mg/dl). In addition to decreased ICU mortality, in-hospital mortality and bloodstream infections also were reduced with intensive insulin therapy. This study is notable in that the vast majority of patients were postsurgical with more than 60 percent admitted following cardiac surgery.

Other investigators have suggested improved outcomes in postcardiac surgery patients with improved glycemic control. A study of more than 3,500 diabetic patients undergoing coronary artery bypass grafting reported an absolute and risk-adjusted decrease in mortality of 57 percent and 50 percent, respectively, and a significant decrease in major infectious complications associated with improved postoperative glycemic control.

While no data exist to guide therapy for intraoperative glycemic management, postoperative data and pathophysiologic reasoning would suggest that improved glycemic control may improve patient outcomes. Until recently no guidelines or position statements regarding inpatient or perioperative glycemic control had been proposed. In December 2003, the American Association of Clinical Endocrinologists convened a consensus development conference on inpatient metabolic control. The purpose of the conference was to bring together international thought leaders in glucose management to develop medical guidelines for inpatient glycemic control, including the perioperative period. Implementing such guidelines during the perioperative period would involve anesthesiologists directly in a variety of settings, and while ASA was invited to provide commentary, there was no opportunity to provide input for development of the position statement.

The position statement considered intravenous insulin to be indicated for glycemic management in critically ill patients during the perioperative period and labor and delivery and following high-dose glucocorticoid therapy. The following guidelines were proposed as upper limits for glycemic targets: ICU patients <110 mg/dl; non-ICU patients <110 mg/dl preprandial, <180 mg/dl maximum; labor and delivery patients <100 mg/dl. The consensus panel members considered 110 mg/dl as the upper limit during the perioperative period.

These new guidelines, if accepted and implemented as suggested, would have profound impact on current anesthesiology practice. The guidelines are intended for all patients, not just those with a diagnosis of diabetes. Furthermore, with a blood glucose >110 mg/dl as an indication for insulin therapy, a large percentage of patients would receive insulin therapy during the perioperative period. With obesity increasing in the United States, it would be expected that the
population at risk for hyperglycemia would only increase in the coming years.

The apparent link between hyperglycemia and outcomes raises other questions as well, including:

- What is the impact on preoperative testing? Is the preoperative medical examination an appropriate time to screen for impaired glycemic control by measuring HbA1c? Does the preoperative metabolic state as measured by serum glucose and glycosylated hemoglobin (HbA1c) predict perioperative hyperglycemia?
- In those patients found to be hyperglycemic, either preoperatively or during the perioperative period, what further testing and care should be performed? Who should provide this care, and how will coordination of these activities occur?
- Is glycemic control indicated in all patients for all procedures? What is the optimal blood glucose level with respect to the risk/benefit of hypoglycemia?
- Determination and management of hyperglycemia requires increased resources. While there may be overall cost savings considering length of stay, prevention of complications and improved quality of life, who will pay for the increased testing and therapy?
- How will institutions review and implement guidelines for inpatient glycemic control? What role will anesthesiologists play in their implementation?

At the least, anesthesiologists need to be aware of the emerging data linking poor outcomes with inpatient hyperglycemia. Practices are changing in ICUs, and, in all likelihood, anesthetic practice will need to change as well. While many questions remain unanswered, anesthesiologists will likely be asked by surgeons, intensivists and perhaps regulating agencies to achieve glycemic control during the perioperative period. The scope of this problem is large, but the potential impact on patient care is even greater.

References:

State Beat: Florida Licenses AAs; Louisiana Bans AAs

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legislative intent to encourage a sufficient ongoing supply of CRNAs in this state and to discourage the creation and authorization of providers of anesthesia not otherwise presently trained and licensed to provide anesthesia. Specifically, it is the intent of the Legislature to prevent the introduction of AAs into Louisiana until such time that they are deemed to be viable providers of anesthesia services. The purpose of this subsection is to carry out that policy in the public interest, providing for the repeal of any provision that provides otherwise.

(3) No health care provider or other person, other than a Certified Registered Nurse Anesthetist, Physician, Dentist, Perfusionist, or other explicitly authorized provider shall select or administer any form of anesthetic to any person either directly or by delegation, unless explicitly authorized by this title.

Blatant factual errors notwithstanding, this bill passed the House by a vote of 81-11 and the Senate by a vote of 37-2. Governor Kathleen Blanco wasted no time in signing the bill into law. Despite the efforts of the Louisiana Society of Anesthesiologists, ASA and the American Academy of Anesthesiologist Assistants, the nurse anesthetists prevailed and have prevented (for now) AAs from practicing in the state of Louisiana.

This effort to ban AAs and to single out anesthesiologists as the only physicians who are prohibited from delegating authority to a nonphysician provider will spread to other states.
Exciting things are happening in the world of anesthesiology, especially if you are a medical student interested in the field. Thanks to the inspiration and generous support of ASA President Roger W. Litwiller, M.D., ASA’s role in supporting education, research and health care delivery may now be expanded to include those medical students interested in anesthesiology. Following an encounter with the President during a medical student luncheon at last year’s Postgraduate Assembly (PGA) in New York, the idea of a “medical student delegation” within ASA came to life.

ASA was founded in 1905 when a group of Long Island physicians organized the first professional anesthesiology society. It has since expanded to provide service and support to more than 39,000 members. ASA is governed by its House of Delegates, and contained within the House are several sections, including the Resident Component. The “Medical Student Delegation,” if successfully launched, will be contained within the Resident Component.

Since that time, we have come quite a long way. The nascent idea that was discussed at the PGA has blossomed and is nearing reality (pending a resolution being presented to the ASA Board of Directors this month). Thanks to the enthusiasm and commitment of ASA, medical students will be offered the opportunity to become more actively involved in ASA. We have been awarded seats in the ASA Resident Component House of Delegates, which will be filled by medical student members when ASA meets for its Annual Meeting this October in Las Vegas, Nevada. This meeting will be an unprecedented opportunity for medical students to observe and learn more about how ASA is governed and presents us with the honor and the opportunity of participating in the shaping of anesthesiology’s future.

The ASA Medical Student Delegation would provide a forum for us to explore the specialty and become involved in local anesthesiology-related groups and activities, formal rotations and a national organization. In addition it will provide a source of information and resources regarding clerkship opportunities, residencies, service projects and research to interested students. We hope to establish an educational relationship with ASA delegates, learn about the legislative process and begin a line of communication between current anesthesiologists and the anesthesiologists of the future so that we can learn from their experience and possibly provide them with fresh ideas and viewpoints. We can best do this if we have a coordinated effort from medical students across the nation. The ASA Medical Student Delegation will give us a voice in the field of anesthesiology that will enable us to advocate for our own needs.

In the future, we hope to grow as a group and gain the support of many Medical Student Delegation members. With sufficient interest and participation, we will be able to organize ourselves, communicate with one another and nominate and elect our own representatives. Our ultimate goal is to become a participating section of ASA. How will we do this? We will begin with a membership list and an e-mail newsletter to correspond with one another. We are currently working on a Web site where interested medical students can access more information and sign up for the Medical Student Delegation <www.urmcaig.org>.

Calling All Medical Students: Be Involved in Your Future!

Emmett Whitaker
Cheri A. Camacho

“The ASA Medical Student Delegation will give us a voice in the field of anesthesiology that will enable us to advocate for our own needs.”

Emmett Whitaker is in his third year of medical school at the University of Rochester School of Medicine and Dentistry, Rochester, New York. Cheri A. Camacho is in her third year of medical school at the University of Rochester School of Medicine and Dentistry, Rochester, New York.
By now you might be asking, “What can I do to help?” Well, get involved! You can start by becoming a medical student member of ASA, if you are not one already, or encouraging a medical student to join. You can find the application at <www.ASAhq.org/studentapp.pdf>. The cost is nominal, and medical students will receive many membership benefits, including a free subscription to the specialty’s most circulated peer-reviewed journal, *Anesthesiology*.

Once you have done that, we would love to hear from you. We need as many interested medical students as possible so that we can move things forward. If you are interested in becoming involved in the Medical Student Delegation or wish to be a member or know someone who does, please contact us at <aiginfo@urmc.rochester.edu>. We will keep you updated on developments as the Medical Student Delegation grows and expands.

Finally, we would like to encourage any interested medical students to attend the ASA Annual Meeting in Las Vegas on October 23-27. It is a great opportunity to learn more about the specialty and to meet people who know what it is like to be an anesthesiologist. We also would like to extend an invitation to all medical students in attendance at the meeting to join us at the University of Rochester Reception on Sunday evening, October 24, for an informal first gathering.

[Medical student membership in ASA, which costs $10, allows you access to an array of educational and informational events at the ASA Annual Meeting.]

We hope you will join us in being involved in this amazing opportunity for medical students. Let us take full advantage of it to ensure our place in the future of anesthesiology. We hope to hear from you soon and to see you in Vegas!

Please send any topic ideas, sample articles or questions to the editors of “Residents’ Review” at <residents.review@ASAhq.org>.

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**ACE Program Available Soon: Subscribe Today!**

ACE, or Anesthesiology Continuing Education, is a new ASA continuing medical education (CME) product designed to facilitate lifelong learning and prepare anesthesiologists for Maintenance of Certification in Anesthesiology (MOCA). ACE is a CME opportunity that does not require travel. With ACE, practitioners can assess the status of their knowledge, identify areas for improvement and prepare for written anesthesiology recertification examinations.

Scheduled for an October 2004 release, the ACE program initially will be available in booklet form only, although an electronic version is expected in the future. ASA is accepting subscriptions for the initial 2004 single issue, the 2005 standard double issue, or both. Please contact the publications department at the ASA Executive Office at (847) 825-5586 or by fax at (847) 825-1692 to request additional information and a subscription form. Subscription forms also can be downloaded from the ASA Web site at <www.ASAhq.org> under “Continuing Education Resources.”
Important Annual Meeting Registration Information

Registration for the ASA 2004 Annual Meeting to be held October 23-27 in Las Vegas, Nevada, is now available on the Web, and the process has never been more convenient.

Just log on to <www2.ASAhq.org> and navigate through the “ASA Annual Meeting” online registration icons. You will be able to access scientific sessions, exhibitor information, housing and activities in Las Vegas.

The initial preregistration deadline is September 22. After that date, online registration only will be available until October 12. All requests for refunds or exchanges must be in writing. Individuals who register by September 22 and who will receive their tickets in the mail must return the tickets they wish to cancel or exchange for receipt by ASA no later than October 12. No refunds or exchanges will be allowed after October 12.

Residents’ Research Essay Award Recipients Honored

Michael K. Cahalan, M.D., Chair of the Committee on Research, has announced that the committee will award prizes for the following three entries in the ASA 2003 Residents’ Research Essay Award:

**First Prize**
George Gallos, M.D., College of Physicians and Surgeons, Columbia University, New York, New York, for “Local Anesthetics Reduce Mortality and Protect Against Renal and Hepatic Dysfunction in Murine Septic Peritonitis.”

**Second Prize**
Claudia Benkwitz, M.D., University of Wuerzburg, Wuerzburg, Germany, for “Influence of GABA<sub>A</sub> Receptor Y<sub>2</sub> Splice Variants on Isoflurane Modulation.”

**Third Prize**
Jacob Raphael, M.D., Hadassah-Hebrew University Medical Center, Jerusalem, Israel, for “Mechanisms of Ischemic Preconditioning: A Potential Protective Role of the Hypoxia Inducible Factor 1 in a Rabbit Model of Regional Myocardial Ischemia.”

Recipients receive a plaque to acknowledge their achievement and the opportunity to present their papers at the awards ceremony and oral scientific poster presentation during the ASA Annual Meeting in Las Vegas, Nevada, on Sunday, October 24, at 8 a.m. during the House of Delegates meeting in the Las Vegas Hilton.

ABA Announces …

ABA Recertification Examination Dates

The transition from a voluntary recertification examination program to maintenance of certification began in January 2004. Only American Board of Anesthesiology (ABA) diplomates certified before 2000 are eligible for the recertification program. Participation will not jeopardize their diplomate status. Diplomates who might have a future need to recertify should consider participating in the program before it closes. The last year in which ABA will administer its recertification examination is 2009.

Eligible diplomates may take the examination by computer at more than 350 test centers during a two-week period from July 9-23, 2005. Recertification candidates will receive test site information by May 15, 2005. Diplomates may apply electronically at the ABA Web site <www.TheABA.org>, download an application from the Web site or request the form by writing ABA at 4101 Lake Boone Trail, Suite 510, Raleigh, NC 27607-7506. Applicants may file their application directly from the Web site or via mail.

Applications will be available October 15, 2004. The standard deadline for the ABA to receive a completed recertification application is December 15, 2004. ABA will consider applications received by January 15, 2005, with payment of an additional fee for late filing. The Board will not consider applications received after January 15, 2005.
Congratulations Not in Order

In his November 2003 NEWSLETTER article, Alan W. Grogono, M.D., wrote, “… in the succeeding few years, the majority continued to find jobs without delay.” This is nothing to cheer about. If the majority, even an overwhelming majority, of anesthesiologists were able to find employment, then a minority were not. Dr. Grogono and academic anesthesia should be outraged, not pleased. If even one CA-3 resident graduates without a job, then how can Dr. Grogono justify an “increase [of] the number of residency positions”? Academic anesthesia should only congratulate itself when every graduating resident segues into a suitable practice.

Ensuring “an infinite supply” of anesthesiologists, as Jill E. Beland, M.D., recently recommended will do many of those already in, and virtually all of those entering, our specialty tremendous harm. Primarily benefiting from the endless supply will be medical insurance payers, hospital CEOs and private anesthesiology practice senior partners. Since anesthesiologists have been and will continue to be a fungible commodity, the “golden opportunities” Dr. Beland described will disappear from America faster than enflurane did.

In the very near future, no longer able to defer her student loans and no longer having an advocate to protect her work hours and her interests, the “financial and social challenges” faced by Dr. Beland in private practice will be much worse than during her residency.

But if academic anesthesiology wants, in several years, its graduating residents to earn $50,000 working 50 weeks per year with reduced benefits, little or no professional respect and the constant threat of being replaced on a moment’s notice, then it should simply follow Dr. Grogono’s advice: “Increase the number of residency positions” and “keep the information shielded …”

How many graduating neurosurgery residents were unable to find jobs during the past 10 years? Not one, I’m sure.

david breznick, m.d.
iron mountain, michigan

References:

Editor’s Note: Dr. Breznick’s position may be a bit overstated. There are many economic factors to consider, as there are countless reasons why a particular resident may not find a job after graduation. If we as a specialty remain in critically short supply, there will be a great temptation by hospital administrators and others to seek alternatives to anesthesiologists. Please see the recent article by Gifford V. Eckhout, Jr., M.D., titled “Where Are Those Anesthesiologists? Deciphering the Numbers” in the May 2004 ASA NEWSLETTER. There is a danger in being too scarce as well as too numerous.
— D.R.B.

Anesthesia Was Born Here, But How Long Will It Stay?

You definitely are continuing in the tradition of Mark J. Lema, M.D., Ph.D., for lively, challenging and thoughtful questions and opinions.

Asking ourselves about the future of anesthesiology and our relationships with graduates of foreign medical schools (May 2004 NEWSLETTER), I think you might add several other reasons why the article by Alan W. Grogono, M.D., about recruitment made people so angry. Needing foreigners to fill our ranks implies we continue in low status. Compare anesthesiology with family practice, surgery or psychiatry in their need to recruit foreigners as residents. Ask how many Americans are seeking residencies in Korea (you are probably laughing now). We, the richest country in the world, are draining talent from poorer countries.

Does it matter if residents come from Canada, Germany or Australia? Not much. They do not suffer so badly when talent is lost. China does.

But the real issue that makes people mad is that needing foreigners in our specialty is a clear statement that Americans do not care very much about our specialty. We have nurses to do the work. We all know that we could encourage the American Association of Nurse Anesthetists to expand nurse anesthesia training programs and ASA to cooperate and assist with this; we would not be dependent upon foreigners. Thus we are not talking about having to seek recruits from outside the United States at all. We are talking about status, and that is what made people angry.

Status is crucial. Remember President Reagan when he was about to receive his Pentothal and looked around the room and said, “I hope you are all Republicans.”

The views and opinions expressed in the “Letters to the Editor” are those of the authors and do not necessarily reflect the views of ASA or the NEWSLETTER Editorial Board. Letters submitted for consideration should not exceed 300 words in length. The Editor has the authority to accept or reject any letter submitted for publication. Personal correspondence to the Editor by letter or e-mail must be clearly indicated as “Not for Publication” by the sender. Letters must be signed (although name may be withheld on request) and are subject to editing and abridgment.
To meet an anesthesiologist who is struggling with his English is frightening.

Thanks for your provoking thoughts.

Lawrence D. Egbert, M.D.
Baltimore, Maryland

Who Are You Calling Foreign?

As a graduate of a Canadian medical school (Queen’s University, Kingston, Ontario, 1974) I should like to point out that Canadian medical school graduates are not to be confused with graduates from other foreign countries regardless of the intent of the editorial titled “National Resident Matching Program — Are We Asking the Right Questions for the Future of Anesthesiology?” (May 2004). Nevertheless this is implied in the editorial. In fact, all 16 Canadian medical schools are part of the Association of American Medical Colleges and are not considered foreign in the United States. Therefore their graduates are not considered foreign medical graduates in terms of education either.

John K. DesMarteau, M.D.
Washington, D.C.

Anesthesiology’s Best Advertisement is YOU

Reading Dr. Bacon’s thoughtful “From the Crow’s Nest” column in the May 2004 issue reminds me of all the important contributions that non-U.S.-trained anesthesiologists and residents have made and the void that they fill when there is a shortage of U.S.-trained medical students to fill our residency programs. The popularity of our specialty among U.S. medical students is tied to job availability, income and lifestyle perception, all of which change from time to time.

Regardless of their fluctuating interest, we also should continue to do our best to attract the best students from American medical schools. The success of our specialty is based, to some degree, on how successful we are in making the practice of anesthesiology attractive to our medical students whose numbers include, no doubt, many children of the upset physicians in the lounge Dr. Bacon describes. If you have the opportunity, take the time to explain to a medical student what you are doing while placing a spinal or during an intubation, or encourage them to take anesthesiology electives. You never know who you might get excited about our specialty.

Timothy E. McCall, M.D.
Cazenovia, New York


U.S. Is a Foreign Concept

It was indeed refreshing to read your commentary in the May 2004 “From the Crow’s Nest” regarding the prior custom to predict or to determine how anesthesiology fared as a specialty according to the ratio of American/foreign medical graduates in the National Resident Matching Program.

This analysis implied that the more American graduates entered residencies, “the better the crop,” while admitting more foreign graduates meant a “bad year.” Although this classification predated the tenure of Alan W. Grogono, M.D., he continued it until this year when differences were noted between allopathic and osteopathic graduates.

To my knowledge, anesthesiology is the only specialty that has used this tangential reference using the origin of the graduates as an index of quality of their trainees, ignoring the fact that Safar, J.S. Gravenstein, Fink, Ngai, Marx, Gelman, Rendell-Baker, Galindo, Racz, Abouleish, Miguel, Gravlee, Usuibiaga, N. Gravenstein, Hannallah, Cascorbi, Rehder, Ivankovich, De Leon-Casasola, Benzon, Ovassapian and many more have significantly contributed to the teaching, administration and research aspects of our specialty. Not to mention thousands of other foreign graduate colleagues who trained in the United States and are proud members of ASA, who work day in and night out in operating rooms, hand-in-hand with their peers. By the way, Al Grogono is one of us, too.

The United States is a great country that has allowed immigration. Many of those immigrants have risen to positions of wealth, power and intellectual grandeur. Applied to medicine in general and to anesthesiology in particular, immigrant physicians have been able to achieve considerable accomplishments that would have been impossible to attain in our native countries, and we are indeed grateful for such opportunity.

Dr. Bacon, it is evident that you have brought a new perspective to the NEWSLETTER; moreover, by deleting the stigma bestowed by the assumption that admitting into the residency training programs a certain percentage of foreign physicians would be a detriment of the specialty. As with many aspects of American life, and contrary to earlier times, diversity has been found to favorably expose individuals to other points of view and fosters intellectual and social exchange with others. We hope that a two-tier system does not develop now by emphasizing how many allopathic versus osteopathic physicians train in anesthesiology. Meaningful factors that determine the choice of specialty by medical graduates need to be identified rather than to continue to point out trivial differences with the sole purpose of keeping some committee active.

J.A. Aldrete, M.D.
Birmingham, Alabama
Get Aware Of It All

We read with interest the recent letter by Michael W. Abajian, M.D., (May 2004) titled “A New Level of Awareness.” In this letter, he suggests that intraoperative awareness has been sensationalized by the media with the help of “unsubstantiated research” and “researchers who have a conflict of interest.” Conspicuously absent from Dr. Abajian’s letter, however, is any attempt to consider the actual data concerning intraoperative awareness. We hope that readers of the ASA NEWSLETTER will have the integrity to examine the data for themselves and make an educated decision about whether intraoperative awareness is a significant problem. We would like to suggest the following list of articles as “required reading” in this area. There are numerous other articles worth reading, but we believe that every member of ASA should be able to find the time to read the “short” list (in chronological order):


And the accompanying comment:


We hope that ASA NEWSLETTER readers will appreciate that these papers represent an international effort to study a problem that transcends the bias of any particular author.

Peter S. Sebel, M.B., Ph.D.
Emory University School of Medicine,
Atlanta, Georgia

T. Andrew Bowdle, M.D., Ph.D.
University of Washington Medical Center,
Seattle, Washington

Mohamed M. Ghoneim, M.D.
University of Iowa, Iowa City, Iowa

Ira J. Rampil, M.D.
State University of New York, Stony Brook, New York

Roger E. Padilla, M.D.
Memorial Sloan-Kettering Cancer Center,
New York, New York

Tong J. Gan, M.D.
Duke University, Durham, North Carolina

Karen B. Domino, M.D.
Harborview Medical Center, Seattle, Washington

*Dr. Sebel is a paid consultant to Aspect Medical Systems. Dr. Sebel and the other authors have received research grant support from Aspect Medical Systems.

Editor’s Note: Many anesthesiologists have been enraged by the comments attributed to their colleagues as well as those from the manufacturer in the lay press. The most difficult part for me personally is the discrepancy between the perception that bispectral index monitoring eliminates recall, as has been insinuated to the general public, and the more complex scientific fact concerning the impact on incidence. There remain difficulties in definitions of terms and interpretation of the data. ASA has appointed a task force to study this problem, and its report will be forthcoming.

— D.R.B.

A Thorough Examination of June NEWSLETTER

Your “Message from Baltimore” in the June 2004 ASA NEWSLETTER was a really thoughtful and important message, one I hope will be read by future oral examination candidates from around the world.

Looking back the many years since, with the usual trepidations, I took the exam in Tampa, Florida; I can recall the rumors that flew about. Your editorial should be required reading to set the record straight on whether there are biased examiners, “easy” ones, “terrorists,” etc. I commend you for this clarifying message.

One other comment: In the same NEWSLETTER, Mark J. Lema, M.D., Ph.D., in his thoughtful “Reflections” on Leroy Vandam, M.D., included an illustration by Dr. Vandam from his *Introduction to Anesthesia* textbook. It surprised me to see the mislabeling that was reproduced, probably countless times, of the right and left hands. (I tried to conceptualize this as a simple flip-flop of the original illustration, but that wasn’t possible.) Surely this must have been noticed by other readers?

Sheafe Ewing, M.D.
Walnut Creek, California
The Foundation for Anesthesia Education and Research (FAER) Board of Directors is pleased to announce the award recipients from the February 2004 submissions. The Foundation is grateful to ASA, its individual members, component societies, subspecialty societies and corporations for their generous contributions, which allow the funding of these awards. We also appreciate the work of all the applicants who submitted proposals and the ASA Committee on Research for review of the proposals.

Application deadlines for the FAER award program are February 15 and August 15 of each year. For the latest information, please see FAER’s Web site at <www.FAER.org>.

Research in Education Grant Recipient ($25,000 for two years)

Susan Tebich, M.D., Cleveland Clinic Foundation, Cleveland, Ohio: “Validation of a Method to Predict Sedation-Induced Upper-Airway Obstruction.” Mentor: Armin Schubert, M.D.

Research Fellowship Grant Recipient ($50,000 for one year)

Ken M. Brady, M.D., Johns Hopkins Hospital, Baltimore, Maryland: “The Role of Cytosolic Phospholipase A2 alpha in Stroke Pathogenesis.” Mentor: Raymond Koehler, Ph.D.

Research Starter Grant Recipients ($85,000 for two years)

Suzanne B. Karan, M.D., University of Rochester, New York: “Validation of a Method to Predict Sedation-Induced Upper Airway Obstruction.” Mentors: Denham S. Ward, M.D., Ph.D., Michael L. Perlis, Ph.D.

Frederick W. Lombard, M.B., Ch.B., Duke University Medical Center, Chapel Hill, North Carolina: “The Role of Platelet-Derived Growth Factor AB in Vasospasm Following Subarachnoid Hemorrhage in the Rabbit.” Mentors: Laura E. Niklason, M.D., Ph.D., Cecil O. Borel, M.D.

Christina M. Pabelick, M.D., Mayo Clinic and Foundation, Rochester, Minnesota: “Regulation of Sarcoplasmic Reticulum Ca2+ Stores in Airway Smooth Muscle: The Role of Cyclic Nucleotides.” Mentors: Gary C. Sieck, Ph.D., David O. Warner, M.D.

Kane O. Pryor, M.B., Weill Medical College of Cornell University, New York, New York: “Resistance of Negative Emotional Memory to GABA Drug Effect.” Mentor: Robert A. Veselis, M.D.

Research Training Grant Recipients ($175,000 for two years)

A. Murat Kaynar, M.D., Harvard Medical School, Boston, Massachusetts: “The Role of Matrix Metalloproteinases and Neutrophil Elastase in the Pathophysiology of Ventilator-Induced Lung Injury.” Mentor: Steven D. Shapiro, M.D.


Wolfgang Steudel, M.D., University of Colorado Health Sciences Center, Denver, Colorado: “HMG-CoA-Reductase Inhibitors and Pulmonary Hypertension.” Mentor: Uwe Christians, M.D., Ph.D.